January – February 2018

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...

CHIP Renewed for Six Years As Congress Votes to Reopen Federal Government

JULIE ROVENER, KHN.ORG

A brief, partial shutdown of the federal government ended Monday, as the Senate and House approved legislation that would keep federal dollars flowing until Feb. 8, as well as fund the Children's Health Insurance Program for the next six years. President Donald Trump signed the bill Monday evening.

The CHIP program, which provides coverage to children in families who earn too much to qualify for Medicaid but not enough to afford private insurance, has been bipartisan since its inception in 1997. But its renewal became a partisan bargaining chip over the past several months.

The Georgetown University Center for Children and Families estimated that 24 states could face CHIP funding shortfalls by the end of January, putting an estimated 1.7 million children's coverage at risk in 21 of those states.

In October, just days after the program's funding expired, the Senate Finance Committee approved a bipartisan five-year extension of funding by voice vote. But that bill did not include a way to pay the cost, then estimated at $8.2 billion.

In November, the House passed its own five-year funding bill for the program, but it was largely opposed by Democrats because it would have offset the CHIP funding by making cuts to Medicare and the Affordable Care Act (ACA).

Prospects for a CHIP deal brightened earlier this month when the Congressional Budget Office re-estimated how much the extension of funding for the program would cost. In a letter to Senate Finance Committee Chairman Orrin Hatch (R-Utah) on Jan. 5, CBO said changes to health care made in the tax bill would result in lowering the five-year cost of the program from $8.2 billion to $800 million — effectively a reduction of 90 percent.

The reason, explained CBO, is that the landmark tax bill passed in December eliminated the ACA's individual mandate, which would likely drive up premiums in the individual market. Those higher premiums, in turn, would increase the federal premium subsidies for those with qualifying incomes. As a result, if kids were to lose their CHIP coverage and go onto the individual exchanges instead, the federal premium subsidies would cost more than their CHIP coverage.

Driving that point home, on Jan. 11, CBO Director Keith Hall wrote to Rep. Frank Pallone (D-N.J.) that renewing CHIP funding for 10 years rather than five would save the federal government money. "The agencies estimate that enacting such legislation would decrease the deficit by $6.0 billion over the 2018-2027 period," the letter said.

For the complete article please visit: https://khn.org/news/chip-renewed-for-six-years-as-congress-votes-to-reopen-federal-government/

Cleveland Clinic, CareSource Sign Long-Term Contract

SHANNON FIRTH, MEDPAGETODAY.COM

CLEVELAND, Ohio - The Cleveland Clinic and CareSource signed a long-term Medicaid contract, after months of negotiations. The deal will allow those with CareSource Medicaid and MyCare plans to continue to have access to the Clinic. An estimated 61,000 people with CareSource receive primary care through the Clinic.

The news comes one week after open enrollment for Medicaid began. Those on Medicaid have until Nov. 30 to enroll in a plan for 2018.

In a joint statement, the companies said: "We are pleased to announce that Cleveland Clinic and CareSource have signed a long-term contract solidifying that CareSource Medicaid and MyCare members can continue to have their care covered at Cleveland Clinic without any interruption. This comes following months of diligent discussions dedicated to working toward an agreement and upholding our combined commitment to provide Medicaid and MyCare patients with access to the highest level of healthcare. We look forward to continuing to serve the needs of our patients/members together."

In July, the Clinic and CareSource warned their contract together would expire Aug. 31, which would have left thousands of CareSource members without access to the Clinic.

Days before that deadline, the two companies extended their contract through Nov. 30 while they tried to agree on a long-term contract.

Both said they were confident they would come to an agreement by Dec. 1, which would have been one day after open enrollment ended.

CareSource's Medicaid contract with the Clinic initially was going to terminate because the two were unable to agree on a payment structure.

In an August interview, Steve Ringel, president of the Ohio market for CareSource, said the company had since secured with the Clinic a value-based payment system, which it uses with most of the other healthcare providers in the state, but was still ironing out more details with the Clinic.

Those final terms of the deal involved figuring out how to implement the new payment structure and expanding the contract to include new hospitals in the Clinic's system, such as Akron General and Avon Hospital.

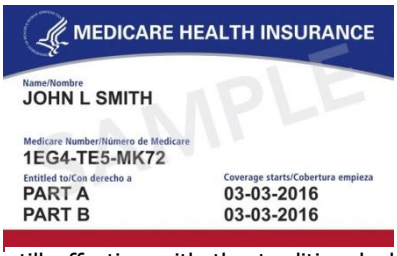
For the complete article please see the following link: http://www.cleveland.com/healthfit/index.ssf/2017/11/cleveland_clinic_caresource_si.html

CMS Medicare Did You Know?

2018 Medicare Deductible is $183

Medicare is removing the social security number from ID cards to fight medical identity theft for people with Medicare. By replacing the SSN-based HICN on all Medicare cards, they seek to better protect private health care information (PHI) and federal health care benefit and service payments.

Moving to new Medicare Numbers and cards requires a lot of changes the Medicare database. Changes have been implemented and Medicare is trying to transition this by April 2018. Beginning in April 2018, they will start mailing the new Medicare cards with the MBI to all people with Medicare in phases by geographic location. The proposed transition period runs through December 31, 2019, after January 1, 2020 all providers will be required to bill with the MBI instead of the HIC number. Throughout the transitional period providers can use either number, but it is highly encouraged to 1.) obtain a copy of the patients new card so you know their Medicare is still effective with the traditional plan and 2.) start billing with the preferred identifier for patient privacy. We have included a sample of the new ID card so you know what to request from patients.



Additionally, HIPAA requires providers to verify patient Medicare coverage every year from January – April. This is because the Medicare open enrollment period is in November/December of the prior year, and patients have the option to switch back to their plan from the prior year during January – February, but are required to stick with it for the year if they do not change it before March. Verifying coverage prevents problematic denials and erroneous, time-consuming claim issues.

More information on the new Medicare ID cards can be found at: https://www.cms.gov/Medicare/New-Medicare-Card/

Congress Passes 2-Year Delay of Medical Device Tax

Michael Smith – MedPageToday.com

Congress voted in favor of a stopgap spending bill Monday that ended the government shutdown and further delayed the enforcement of a 2.3 percent medical device tax, reports *STAT.*

1. Federal officials first imposed the 2.3 percent tax on certain medical devices in January 2013 to help fund the ACA. After receiving harsh criticism from legislators and the medical device industry, Congress passed a two-year suspension of the levy in 2015, Congress passed a two-year suspension of the levy in 2015.

2. The delay on the ACA's medical device tax was set to expire Jan. 1 and the first payments of the tax were due to the Treasury Department Jan. 29.

3. However, the stopgap bill — signed into law Monday by President Donald Trump — further delays the medical device levy for another two years. The language of the spending deal also retroactively delayed the tax beginning Dec. 31, 2017, so no taxes are due to the Treasury Department.

4. The tax will now go into effect Jan. 1, 2020, unless Congress passes a permanent repeal of the tax.

For more information please visit: https://www.beckershospitalreview.com/supply-chain/congress-passes-2-year-delay-of-medical-device-tax-4-things-to-know.html

Fight Continues Against Anthem Pay Cut for Same-Day Services

Andis Robeznieks – Wire.ama-assn.org

Physicians have vowed to continue pushing back against a health insurer's plan to reduce payment for significant, separately identifiable evaluation and management services that are provided on the same day as a procedure or a wellness exam.

Indianapolis-based Anthem Blue Cross Blue Shield announced last week it would reduce the size of its planned payment cut for such services from 50 percent to 25 percent and move the implementation date back from Jan. 1, 2018, to March 1, 2018.

The announcement came after the AMA sent a letter to Anthem requesting that the company halt plans to implement the policy and a face-to-face meeting was held between AMA leaders and senior Anthem officials.

While noting that the dialogue the AMA has had with Anthem management "is appreciated," the Association is making it clear that Anthem's moves did not go far enough.

The AMA provided Anthem with information clarifying how the recommendations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) do not include duplicative physician work or practice expense for procedures typically billed with an E/M service on the same date. The Association also gave Anthem further supportive data on those procedures for which practice expense already has been reviewed by the RUC.

Using Medicare payment data, the AMA also showed Anthem's leaders instances in which the proposed lower payments would not even cover direct practice expenses when a needed minor procedure was performed on the same day as an office visit. That would result in a financial loss for physician practices offering timely, high-quality care.

"Anthem's decision to reduce the magnitude of the proposed payment cuts in response to evidence supplied by AMA is a positive step, as is the plan to delay implementation until March 1," said Jack Resneck Jr., MD, chair-elect of the AMA Board of Trustees. "However, the AMA continues to challenge Anthem's rationale for the unjustified 25 percent reduction proposed in the revised policy. AMA leadership is pursuing further discussions with Anthem to seek additional changes in their flawed policy."

The reduction targets E/M services billed with a Current Procedural Terminology (CPT) modifier 25 for a significant and distinct health problem when performed on the same day and by the same provider as a minor surgical procedure code or a preventive/wellness exam. Appropriate use of .25 modifier facilitates provision of unscheduled, medically necessary care and, consequently, prompt diagnosis and streamlined treatment. Physicians' efforts to provide patient-centric care will be disrupted by implementation of Anthem's policy.

"Health insurers that reduce or deny payment for E/M services associated with procedures performed on the same day are needlessly forcing patients into multiple visits and delaying the provision of necessary care," said AMA President David O. Barbe, MD, MHA, at the 2017 Interim Meeting held in November.

The HOD directed the AMA to "aggressively and immediately advocate" that, when an E/M code is appropriately reported with a modifier 25, that both the procedure and E/M service are paid at the allowable rate without reduction.

For the complete article please visit: https://wire.ama-assn.org/practice-management/fight-continues-against-anthem-pay-cut-same-day-services?utm_source=BulletinHealthCare&utm_medium=email&utm_term=122917&utm_content=general&utm_campaign=article_alert-morning_rounds_daily

Allscripts Buys Practice Fusion for $100 Million

Mike Miliard – HealthcareITNews.com

Allscripts continues to be in acquisition mode, further building out its client base in the ambulatory space by buying Practice Fusion for $100 million in cash. The deal is expected to close in the first quarter of 2018, officials said.

The addition of San Francisco-based Practice Fusion, whose cloud-based electronic health record is aimed primarily at small, independent physician practices, will give Allscripts a larger footprint in outpatient settings.

It's the second move in less than six months – following the acquisition of McKesson's health IT business in August 2017 – designed to expand the Chicago vendor's nationwide market share.

Some 30,000 ambulatory sites, serving about 5 million patient each month, currently use Practice Fusion EHR, practice management, e-prescribing, lab and patient portal technology.

Allscripts also sees the company – which was founded as a startup a dozen years ago and grew as a free, web-based EHR to help small doc practices earn meaningful use incentives – as a way to expand its access to clinical data that can help it innovate in an array of areas: analytics and interoperability, life sciences and clinical trials.

"Combined with Practice Fusion, we expect Allscripts to continue to drive innovation in addressing gaps-in-care, improving clinical outcomes and real-world-evidence research," said Allscripts President Rick Poulton in a statement. "Plus, Practice Fusion's affordable EHR technology supports traditionally hard-to-reach independent physician practices, and its cloud-based infrastructure aligns with Allscripts forward vision for solution delivery."

Poulton said existing Practice Fusion clients would benefit from the deal, given new access to Allscripts technology.

http://www.healthcareitnews.com/news/allscripts-buys-practice-fusion-100-million

Senate Tax Bill Eliminates the Individual Mandate for Health Insurance

Elizabeth O'Brien – Time.com

In December the Senate voted to pass the Republican Party's sweeping tax reform bill, and among other provisions, the bill would eliminate the penalty for not buying health insurance starting in 2019.

The individual mandate clause of the Affordable Care Act (a.k.a. Obamacare) requires individuals to buy insurance or pay a penalty at tax time, unless they qualify for a limited number of exemptions. Beginning in 2019 consumers will be able go without coverage and not face a fine. The penalty for going uncovered for 2018 will be $695 per adult or 2.5% of household income in excess of tax filing thresholds, whichever is higher.

For now, the individual mandate penalty remains in place for 2018. Existing customers should **s**hop around rather than allow the system to re-enroll them in their current plans, says Sabrina Corlette. There are plenty of bargains out there: Kaiser Family Foundation estimates that more than half of subsidy-eligible, uninsured individuals could buy a bronze-level plan for no premium contribution—that is, a $0 premium.

http://time.com/money/5043622/gop-tax-reform-bill-individual-mandate/

Watch for Medicaid Revalidations in the Mail

Medicaid is sending revalidation letters for individual providers and group practices, requiring the individual or the group to REVALIDATE with Medicaid. Medicaid has coordinated this with the five year anniversary of the provider or group's participation with Medicaid. Failure to revalidate with Medicaid means they will shut off all payments on Medicaid claims. Medicaid will mail three notices, three months apart, to your practice's address, your business address or your remittance address. They will first send you a revalidation notice, followed by a second notice a month later. The third and final notice will advise you if the revalidation is not completed by the date specified your payments will be turned off. NCDS will immediately notify you if we receive a notice on behalf of your practice or find information indicating your practice has been selected for revalidation. Notices sent to individual providers will be the responsibility of those individuals to watch for and/or monitor. Should you need assistance with your Medicaid revalidation please contact us upon receipt of your revalidation letter.

U.S. Flu Season Gets Worse, Has 'A Lot More Steam' Than Expected

Mike Stobbe – ABCNews.com

The flu season in the U.S. is getting worse. Health officials last week said flu was blanketing the country but they thought there was a good chance the season was already peaking. But the newest numbers out Friday show it grew even more intense.

"This is a season that has a lot more steam than we thought," said Dr. Dan Jernigan of the U.S. Centers for Disease Control and Prevention. One measure of the season is how many doctor or hospital visits are because of a high fever, cough and other flu symptoms. Thirty-two states reported high patient traffic last week, up from 26 the previous week. Overall, it was the busiest week for flu symptoms in nine years.

Hawaii is the only state that doesn't have widespread illnesses.

This year's flu season got off to an early start, and it's been driven by a nasty type of flu that tends to put more people in the hospital and cause more deaths than other common flu bugs. In New York, state officials say a drastic rise in flu cases hospitalized more than 1,600 this past week.

The flu became intense last month in the U.S. The last two weekly report show flu widespread over the entire continental United States, which is unusual.

Usually, flu seasons start to wane after so much activity, but "it's difficult to predict," Jernigan said. Flu is a contagious respiratory illness, spread by a virus. It can cause a miserable but relatively mild illness in many people, but more a more severe illness in others. Young children and the elderly are at greatest risk from flu and its complications. In a bad season, there as many as 56,000 deaths connected to the flu. In the U.S., annual flu shots are recommended for everyone age 6 months or older.

In Oklahoma and Texas, some school districts canceled classes this week because so many students and teachers were sick with the flu and other illnesses. In Mississippi, flu outbreaks have hit more than 100 nursing homes and other long-term care places, resulting in some restricting visitors.

For the complete article please visit:
http://abcnews.go.com/Health/wireStory/us-flu-season-worse-lot-steam-expected-52472983

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