July - August 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...

CMS Proposes Historic Changes to Modernize Medicare and Restore the Doctor-Patient Relationship

CMS.gov

On July 12, CMS proposed historic changes that would increase the amount of time that doctors and other clinicians can spend with their patients by reducing the burden of paperwork that clinicians face when billing Medicare. The proposed rules would help restore the doctor-patient relationship by empowering clinicians to use their Electronic Health Records (EHRs) to document clinically meaningful information, instead of information that is only for billing purposes.

"Today's reforms proposed by CMS bring us one step closer to a modern health care system that delivers better care for Americans at a lower cost," said HHS Secretary Alex Azar. The ambitious reforms proposed by CMS under Administrator Verma will help deliver on two HHS priorities: creating a value-based health care system for the 21st century and making prescription drugs more affordable."

"Today's proposals deliver on the pledge to put patients over paperwork by enabling doctors to spend more time with their patients," said CMS Administrator Seema Verma. "Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care. This Administration has listened and is taking action. The proposed changes to the Physician Fee Schedule and Quality Payment Program address those problems head-on, by streamlining documentation requirements to focus on patient care and by modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need."

The proposals, part of the Physician Fee Schedule (PFS) and the Quality Payment Program (QPP), would modernize Medicare payment policies to promote access to virtual care, saving Medicare beneficiaries time and money while improving their access to high-quality services no matter where they live. Such changes would establish Medicare payment for when beneficiaries connect with their doctor virtually using telecommunications technology (e.g., audio or video applications) to determine whether they need an in-person visit. Additionally, the QPP proposal would make changes to quality reporting requirements to focus on measures that most significantly impact health outcomes. The proposed changes would also encourage information sharing among health care providers electronically, so patients can see various medical professionals according to their needs while knowing that their updated medical records will follow them through the health care system. The QPP proposal would make important changes to the Merit-based Incentive Payment System (MIPS) "Promoting Interoperability" performance category to support greater EHR interoperability and patient access to their health information.

If these proposals were finalized, clinicians would see a significant increase in productivity – leading to substantially more and better care provided to their patients. Removing unnecessary paperwork requirements through the PFS proposal would save individual clinicians an estimated 51 hours per year if 40 percent of their patients are in Medicare. Changes in the QPP proposal would collectively save clinicians an estimated 29,305 hours and approximately $2.6 million in reduced administrative costs in CY 2019.

The proposed changes to the PFS would reinforce CMS' *Patients Over Paperwork* initiative focused on reducing administrative burden while improving care coordination, health outcomes, and patients' ability to make decisions about their own care. Responding to stakeholder concerns, several provisions in the proposed CY 2019 PFS would help to free EHRs to be powerful tools that would actually support efficient care while giving physicians more time to spend with their patients, rather than on paperwork. Most importantly, this proposal would simplify, streamline and offer flexibility in documentation requirements for E&M office visits which make up about 20% of clinician's time.

Additionally, "CMS is committed to modernizing the Medicare program by leveraging technologies, such as audio/video applications or patient-facing health portals, that will help beneficiaries access high-quality services in a convenient manner," said Administrator Verma. Provisions in the proposed CY 2019 PFS would support access to care using telecommunications technology by paying clinicians for virtual check-ins – brief, non-face-to-face appointments via communications technology, paying clinicians for evaluation of patient-submitted photos and expanding Medicare-covered telehealth services to include prolonged preventive services

President Trump is putting American patients first and lowering prescription drug costs. CMS is proposing changes that would affect payment under Medicare Part B so that the payment amount would more closely match the actual cost of the drug. This change would be effective January 1, 2019, and would reduce the amount that seniors would have to pay out-of-pocket, especially for drugs with high launch prices. This is one of many steps that CMS is taking to ensure that seniors have access to the drugs they need.

Please visit this link for more information and helpful tools: https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html

NCDS Perspective: #PatientsOverPaperwork is an initiative that answered a calling from both patients and providers. There are so many beneficial changes packed into this proposal it was hard to fit it all on one page! While this may come as a blow to EMR tech companies and big pharmaceutical corporations, this proposal is a huge win for doctors and their patients, increasing patient care, reducing the burdens with paperwork/EMRs, expanding telemedicine to provide additional layers of service to patients and reducing drug costs for seniors. NCDS will be following the proposal closely and the outcome of the finalized provisions for the 2019 calendar year.

Short Term Health Insurance: 4 Things to Know

Kelly Gooch – BeckersHospitalReview.com

The Trump administration released a final rule for short-term health plans Aug. 1. Under the rule, Americans will be allowed to buy short-term health insurance plans that offer longer coverage. Previously, plans could only last up to three months. Coverage can now last less than a year, and extensions and renewals can last up to three years, depending on states' decisions. The rule is slated to take effect 60 days after publication in the federal register. Here are 4 things to know about these plans:

1. Short-term plans do not have to abide by rules set by the ACA requiring coverage of essential health benefits and pre-existing conditions. They also do not have to comply with ACA rules that ban major medical plans from imposing limits on how much care is covered, or the ACA's requirement that at least 80 percent of premium money go toward care.

2. Because they aren't required to comply with these ACA rules, short-term plans tend to not cover as much care as more comprehensive, ACA-compliant plans. Specifically, they tend to not cover prenatal and maternity care; mental health and drug treatment; and prescription drugs, reports *The New York Times*. 3. Short-term plans also have coverage limits. For instance, a typical short-term plan does not cover $250,000 to $2 million in care, according to a Kaiser study cited by the *Times*. There may be other exclusions with short-term plans.

4. Not having to comply with ACA rules means short-term plans are generally cheaper than more comprehensive coverage. The Kaiser study found the monthly premium for the least expensive ACA plan for a 40-year-old single man in Atlanta was $371, while $47 was the cheapest monthly premium for a short-term plan. In Chicago, an ACA plan was $305 compared to $55 for a short-term plan, in Phoenix, an ACA plan was $405 and short-term one was $36.

For the complete article please visit: https://www.beckershospitalreview.com/payer-issues/short-term-health-insurance-4-things-to-know.html

Icahn to Block $54B Cigna-Express Scripts Merger

Shoshanna Delventhal – Investopedia.com

Billionaire hedge fund manager Carl Icahn has amassed a sizable stake in health insurance industry giant Cigna Corp. (CI) and plans to vote against its proposed $54 billion acquisition of Express Scripts Holding Co. (ESRX) when shareholders vote Aug. 24, as first reported by The Wall Street Journal.

Icahn, a controversial, high-profile activist investor who once served as an advisor to President Trump, holds less than a 5% stake in the insurance company. He reportedly believes that Cigna is paying too high of a price for the pharmacy benefit manager (PBM), which faces various risks including consolidation of industry rivals and the entrance of e-commerce and cloud computing titan Amazon.com Inc. (AMZN) into the market.

In December, drugstore chain and PBM manager CVS Health Corp. (CVS) agreed to buy Cigna insurance rival Aetna Inc. (AET) in a deal worth $69 billion. On Wednesday, California Insurance Commissioner Dave Jones released a report urging the U.S. Justice Department to block to proposed tie up.

https://www.investopedia.com/news/icahn-block-54b-cignaexpress-scripts-merger/

Obese Individuals May Be More Likely to Spread Flu

First evidence of obesity's impact on shedding of the virus, not just its severity

Molly Walker – MedPageToday.com

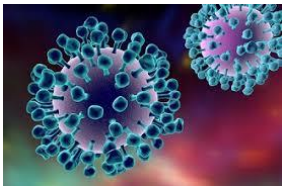
Obese adults with the flu shed the virus longer than non-obese adults, regardless of whether they were symptomatic, researchers found. Symptomatic obese adults shed influenza A for 42% longer than non-obese adults (adjusted event time ratio 1.42, 95% CI 1.06-1.89), reported Aubree Gordon, PhD, of the University of Michigan School of Public Health in Ann Arbor, and colleagues.

Moreover, among cases with ≤1 symptom (not including fever), obese adults shed the virus for 104% longer than non-obese adults (adjusted ETR 2.04, 95% CI 1.35-3.09), the authors wrote in the *Journal of Infectious Diseases*.

Prior epidemiologic studies in *Morbidity and Mortality Weekly Report* and *PLoS Medicine* found an association between obesity and severe complications and death from influenza, especially in the elderly, Gordon's group noted. Obesity "leads to altered immune function and chronic inflammation, which increases with age, in addition to mechanical difficulties in breathing and increased oxygen requirements," but the effect of obesity on less severe influenza had not been well studied.

"This is the first real evidence that obesity might impact more than just disease severity," Gordon said in a statement. "It might directly impact transmission as well."

The team examined two studies of households in Nicaragua -- the Household Influenza Transmission Study and the Household Influenza Cohort Study. In both studies, household members were monitored for 10-13 days after the identification of a symptomatic flu case. Participants filled out daily symptom diaries and had up to five nasal/oropharyngeal swab measurements. Temperature was measured for each household contact during the follow-up period, regardless of symptoms.



Shedding duration was defined as "time from illness onset to viral shedding cessation." Obesity was defined as a body mass index (BMI) ≥30 in adults, and a BMI *z* score of >3 in children younger than 5, or a BMI *z* score of >2 for children ages 5 to 17.

Overall, 1,783 people in 320 households provided 7,066 swab samples for testing (mean 4.0 swabs per participant). There was a median symptom diary duration of 10 days. There were 812 adults ages 18 to 92 in the study. Almost 75% of the adults were women, and about 40% of the adults were obese. In addition, the study included 631 children ages 5 to 17 and 340 children ages 0 to 4.

Not surprisingly, obese individuals with influenza tended to have more symptomatic or severe illness, the authors noted. A lower portion of influenza cases among obese individuals were paucisymptomatic (3.6% versus 16.5% in non-obese individuals) or asymptomatic (16.1% versus 18.7%, respectively).

https://www.medpagetoday.com/infectiousdisease/uritheflu/74383?xid=nl_mpt_DHE_2018-08-03&eun=g259640d0r&pos=&utm_source=Sailthru&utm_medium=email&utm_campaign=Daily%20Headlines%20-%20Salary%20Survey%202018-08-03&utm_term=Daily%20Headlines%20-%20Active%20User%20-%20180%20days

Data Points: As Open Enrollment Approaches, who is uninsured?

Modern Healthcare

Between 2010 and 2017, more than 19 million people moved from the ranks of the uninsured to insured. And from 2015 through 2017, when key elements of the Affordable Care Act were being debated in policy circles, the ranks of the uninsured fell by 2.9 million. With the 2019 open-enrollment season just a few months away, here's a look at some key demographic data.

30.1 million – number of nonelderly uninsured in 2017, down 8.5% from 32.9 million in 2015
11% - Uninsured rate in 2017 for people living in households earning up to 400% of the federal poverty level (the cutoff to be eligible for subsidies)
49.2% - Uninsured rate in the South in 2017, highest percentage in the nation

11.4% - Uninsured rate in the Northeast in 2017, lowest percentage in the nation
69.3% Percentage of adults ages 18-64 covered by private insurance in 2017, including 4.3% who got coverage via the ACA exchanges
43.7% Percentage of adults under 65 enrolled in high-deductible health plans in 2017, up from 39.4% in 2016

For the complete article please visit the link below: http://www.modernhealthcare.com/article/20180721/NEWS/307219988/data-points-as-open-enrollment-approaches-who-is-uninsured

10 Best, Worst States for Healthcare

Ayla Ellison – Beckershospitalreview.com

Vermont is the best state for healthcare, according to an analysis by WalletHub.
To identify the best and worst states for healthcare, WalletHub analysts compared the 50 states and the District of Columbia on 40 key metrics of healthcare cost, accessibility and outcomes. The metrics range from physicians per capita to average monthly insurance premiums. Each measure was graded on a 100-point scale, with 100 representing the best healthcare at the most reasonable cost.
https://www.beckershospitalreview.com/rankings-and-ratings/10-best-worst-states-for-healthcare-080618.html

Here are the 10 best states for healthcare based on the analysis:	Here are the 10 worst states for healthcare based on the analysis:
1. Vermont	1. Louisiana
2. Massachusetts	2. Mississippi
3. New Hampshire	3. Alaska
4. Minnesota	4. Arkansas
5. Hawaii	5. North Carolina
6. Rhode Island	6. Alabama
7. Colorado	7. Oklahoma
8. District of Columbia	8. South Carolina
9. Iowa	9. Georgia
10. Maryland	10. Florida

High-Level Patient Visits

Cindy Parman – HBMA RCM Advisor

Medical Decision Making

Medical necessity relates to why the service was necessary or required at a higher visit level, while medical decision making describes the physician's thought process regarding treatment options selected. The medical decision making component of the patient visit service includes the number of diagnostic and management options to be considered, the complexity of data analyzed, and the risk of complications, morbidity, and mortality associated with the presenting problems. Generally, the patient's presenting complaint sets the framework for medical necessity of care rendered during an encounter, as reflected in the code level reported.

Audit Concerns

CMS recognizes that E/M coding errors contribute to overpayments, due to both billing and documentation issues. In a past study, the Office of Inspector General (OIG) reported that 42% of claims were incorrectly coded and 19% lacked documentation in the patient medical record to support the code charged. Most of these situations involved upcoding, which is increasing the charge code to a higher level or more complex service than supported in medical record documentation.

An October 2017 report states that in 2012 there were 1,807 healthcare professionals who charged Medicare for the most expensive established patient visits at least 90 percent of the time. This situation has increased to 1,825 healthcare professionals who charged mostly high-level visits in 2015. For example, a family practice physician in rural Alabama billed Medicare for the highest-level office visits 95% of the time, more than any other physician in the United States. An analysis of federal data indicates that this doctor billed 4,765 high-level visits in 2015 and collected about $450,000 from Medicare.

Although it is possible that a physician may only treat the sickest of patients and code only high-level office visits it does not appear probable to some government investigators. As a result, the government will continue to focus on high-coding physicians, both to improve program oversight and reduce overpayments.

Accurate Documentation Is Key

According to CMS, if it is not documented, it has not been done. Clear and concise medical record documentation is critical to providing patients with quality care and is required for you [the physician] to receive accurate and timely payment for furnished services. Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.

While it is important to bill for the complexity of services performed it is not acceptable to bill for services at the highest level available, when the patient only received basic or routine services. While upcoding remains a problem, some stakeholders point to electronic health records (EHRs) that assign billing codes when the physician clicks boxes during an office visit as the potential culprit. Regardless of how patient visit codes are assigned, physicians should consider monitoring the type and level of codes billed to insurance and make certain that documentation clearly supports the services charged.

Maximize Your Revenue

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