September – October 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…

Over 80,000 Americans Died of Flu Last Winter, Highest Toll in Years

Donald G. McNeil Jr – NYTimes.com

More than 80,000 Americans died of the flu in the winter of 2017-2018, the highest number in over a decade, federal health officials said last week.

Although 90 percent of those deaths were in people over age 65, the flu also killed 180 young children and teenagers, more than in any other year since the Centers for Disease Control and Prevention began using its current surveillance methods.

The estimates were released at a news conference held by the National Foundation for Infectious Diseases to urge Americans to get vaccinated and to fight the myths that scare off some people — such as the common misconception that flu shots can cause flu.

The high mortality rate was unusual because it was caused by a "normal" — albeit severe — flu season, not by a new pandemic influenza strain.

In the 2009-2010 swine flu epidemic, by contrast, 59 million Americans are thought to have caught the novel strain that first appeared in the spring, but only about 12,000 died because the infection was relatively mild, according to the C.D.C. That flu, an H1N1 strain, was called a "swine flu," despite the objections of the pork industry, because it emerged in a pig-farming region of Mexico and was the first human flu virus to contain genes from both North American and Eurasian pig flus.

The dominant strain last season was an H3N2 flu, which is usually the most deadly of the four seasonal flu strains that typically circulate.

Last season's flu vaccine was only about 40 percent effective at preventing infection — approximately the same as the previous season's, according to the C.D.C. Vaccine effectiveness varies quite a bit each year, from a high of 60 percent in 2010-11 to a low of 19 percent in 2014-2015. It is impossible to know yet how effective this year's vaccine will be.

Infectious disease specialists have long expressed frustration that medical science has not come up with a universal lifetime flu vaccine. Currently available vaccines target the spikes on the virus's outer shell, which are the parts that mutate the fastest.

Because it takes more than six months to make each year's vaccine, manufacturers have to choose in February what strains to put into shots that will be shipped in September. During that interim, circulating flus can mutate to become a partial mismatch to whatever was chosen.

But experts still urge people to get even imperfect shots, because while they may be only 40 percent effective at warding off body aches and runny noses, they are much more effective at preventing influenza's worst outcome — death.

For more information on this article please visit: https://www.nytimes.com/2018/10/01/health/flu-deaths-vaccine.html

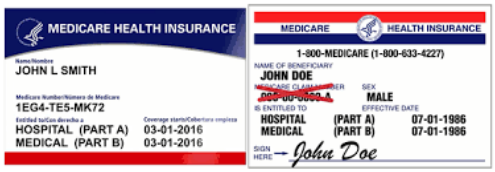
New Medicare Card Scam Hits Nationwide

Maureen Patterson – MyMedicareMatters.Org

Medicare started mailing new Medicare cards to beneficiaries in April and will finish mailing them nationwide in a year. They have a new look but, most importantly, they have unique numbers that are different than the Social Security numbers previously used on the cards. Medicare created the new cards to reduce identity theft and fraud.

Ironically, fraudsters are capitalizing on the mailings to deceive beneficiaries. They may have many details about individuals, often gleaned from social media and other publicly available resources. They sound convincing.

The Senior Medicare Patrol (SMP) helps beneficiaries fight back. SMP staff work in communities across the country to teach beneficiaries how to prevent, detect, and report Medicare fraud, errors, and abuse. Here are some tips to avoid the Medicare card scams that SMPs are seeing.



Scammers try to convince beneficiaries that they need to pay to obtain either a temporary or permanent new card. Costs range from $5 to $400. In another version of this scam, callers, pretending they are from a government agency, say they need the beneficiary's bank account information to deposit funds into their account.

In reality, the new cards do NOT cost anything, and beneficiaries do not need to do anything to get them. Medicare will automatically mail them their new card. (Patients can sign up to get an email from Medicare to know when to expect your card in the mail.)

Scammers try to convince beneficiaries to confirm or give personal information in order to get their new card.

In reality, beneficiaries do NOT need to give out any personal information in order to get their new cards. The cards are mailed to the address Social Security has on file. Beneficiaries can update their address by going online, calling 1-800-772-1213, or visiting their local Social Security office.

In another scam, callers claim they need a beneficiary's old Medicare card number to prevent their insurance from being interrupted while new cards are being mailed out. But patient's shouldn't fear; their medicare policy will not be cancelled and there will be no interruption in service. In fact, both the old and new Medicare numbers may be used through December 2019.

For more information about Medicare card scams and other scams, contact your Senior Medicare Patrol. Find your local office by calling 1-877-808-2468 or go to www.smpresource.org.

Please see the link below for additional details and resources: https://www.mymedicarematters.org/2018/06/new-medicare-card-scams-hit-nationwide/?SID=5baa4cad72bba143

Worried About the 5% MIPS Penalty?

Have you been to the NCDS Blog? To keep our providers up to date on industry changes and important articles our blog is always available as an additional resource. Be sure to stop by the website for helpful information regarding MIPS reporting and other essentials for your practice. NCDS partners with Mingle Analytics to make this process easier for our valued clients who want to spend more time on patient care than regulations, extra paperwork and quality measures.

Gay De Hart – Contribution By Mingle Analytics

Eligible Clinicians may have difficulty finding the time and resources to fully participate in the 2018 MIPS reporting year – especially if you are part of a small practice. CMS has made 2018 another "Transition Year" for the new Quality Payment Program, meaning, they are still allowing different participation options to satisfy reporting requirements to avoid the 5% penalty.

For 2018, practices and eligible clinicians need to earn a Final Score of 15 points out of 100 to avoid a penalty – up from just 3 points in 2017. Practices with 15 or fewer providers, called "small practices," are scored differently than groups with more than 15 providers so there are different options for earning the 15 points. Small practices with 15 or fewer providers receive 5 points added to the score so essentially you only need to 'earn' 10 points. Then small practices have their points doubled for each improvement activity reported.

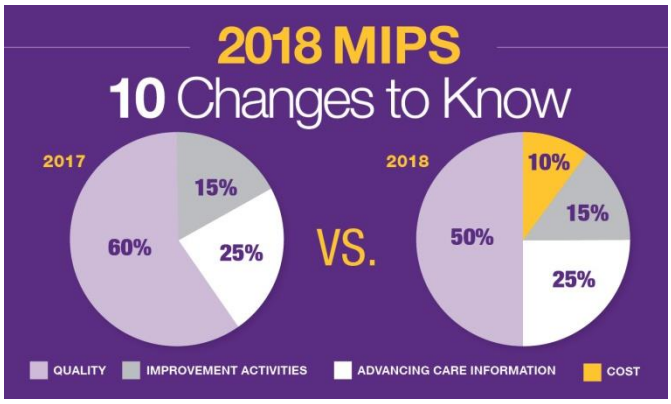
There are different ways a small practice can earn the 15 points for the Final Score. Small practices can earn the required 15 points to avoid a penalty in a few different ways, depending on which performance category and measures they report on. Practices can report on Quality, Promoting Interoperability, Improvement Activities to quickly and easily achieve the required 15 points.

If your practice does not qualify as a small practice but you still want to report the minimum this can easily be achieved by reporting Improvement Activities using 2 high-weighted activities or 4 medium-weighted activities for the final score of 15 points.

MINGLE ANALYTICS

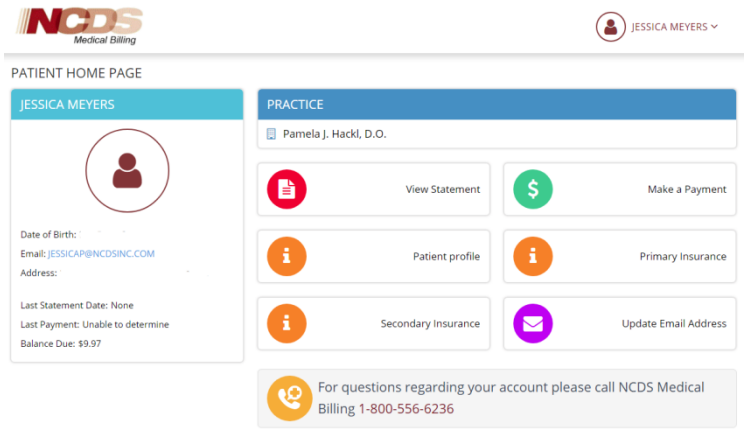
It can be an overwhelming process to report on quality measures, stay current on the many requirements, follow changing government regulations and still focus on patient care. Be sure to utilize our website for important articles and tools to lessen the burden of these requirements and make this process easier!

Please visit: http://www.ncdsinc.com/how-to-simply-avoid-the-2018-mips-penalty/



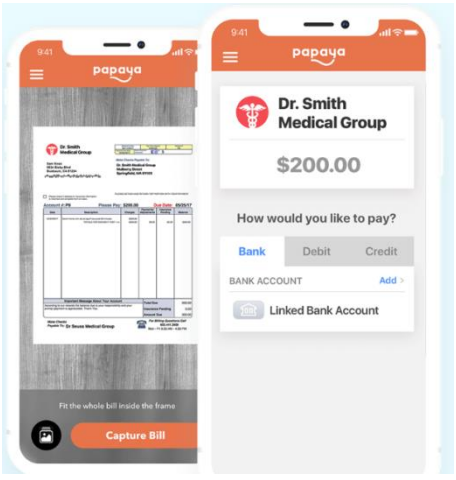
Coming Soon to the NCDSINC.com Website!

NCDS is excited to debut our newly redesigned patient website experience! To make our website more user friendly and improve self-service tools we have redesigned our patient portal. Enhancements include app features like those shown below making it visually more appealing for patients to find the information they need. Here patients can update demographic information, make a payment, update insurance, print a statement and more. These enhancements have also allowed us to update the way our website interfaces with different browsers and mobile devices, letting patients access their information on the go more easily. Look to our website in the coming months for this and other enhancements to make the patient experience even better!



Offering More Ways to Pay – Papaya Payments App

NCDS partnered with Papaya payments in 2017 to offer your patients more ways to pay and patients are using this feature! We offer this feature at no additional cost to the patient or provider, and it is noted on each patient statement for the convenience of your patients. Papaya is a mobile app available in the Apple App Store or Google Play which allows the patient to take a picture of their bill (yours and any others) on their smart phone and submit it through the app for processing. Papaya then contacts the payee and provides the patient's credit card information for processing, upon which the patient receives a confirmation through the app. As more patients move toward more mobile-based solutions NCDS has also adapted to provide options and solutions that best suit your patients' needs.



Ohio Medicaid Open Enrollment is November 1st – 30th

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.

How to Get Patients On Board With Immunization

Sara Berg – AMA

Immunization is one of the most effective interventions for improving public health. Yet each year more than 50,000 adults die from vaccine-preventable diseases or other complications, according to the Centers for Disease Control and Prevention. Because patients avoid vaccination for a variety of reasons, it is important to be mindful of patient concerns and misconceptions. "Patients who wanted vaccines wanted it to be easy for them," said Eileen Barrett, MD, in an interview with *AMA Wire®.* "And the patients who were vaccine hesitant often just needed an extra nudge to make it easy for them."

For easier access, Dr. Barrett and her team created a free-standing immunization clinic with hours of operation between 8 a.m. and 8 p.m., seven days a week, during flu season. And because the clinic was managed by licensed practical nurses (LPNs) with help from an office clerk, physicians' work days went uninterrupted. However, because the clinic was set up in the lobby of the medical practice, physicians were available to address patient uncertainty about vaccinations.

While statistics are important, making it personal by harnessing the power of anecdotes helps get the message across better. "I would say, 'I know a doctor—and this is actually true—who got the flu, had a 104-degree fever and was in bed for five days unable to get up,'" said Dr. Barrett. "I now tell that story because I had just mentioned it to a patient and she gasped and then decided to get her flu shot."

As an internist, she addressed her older patients' needs and concerns by explaining that the flu shot would protect babies. This resonated with her patients because they often care for their grandchildren. She recommended letting them know that because their grandchildren's immune systems aren't strong enough, they can't get their vaccinations until they are six months old. Another way to say it is, "If you won't do it for yourself, do it for your granddaughter because she can't get her shots. Then you can tell everyone else in the family to come in and get their shots to protect her."

For the full article please visit: https://wire.ama-assn.org/delivering-care/how-get-patients-board-immunization

Medicare Advantage Organizations Overturned 75% of Their Denials, Fed Investigation Shows

Kelly Gooch – Beckershospitalreview.com

A recent investigation by the U.S. Office of Inspector General found between 2014 and 2016, Medicare Advantage organizations overturned 75 percent of their preauthorization and payment denials upon appeal.

The OIG's report, released in September, found Medicare Advantage organizations overturned about 216,000 denials annually during the period. Investigators also found that independent reviewers overturned more denials at higher Medicare Advantage appeals levels.

"The high number of overturned denials raises concerns that some Medicare Advantage beneficiaries and providers were initially denied services and payments that should have been provided," the agency wrote. "This is especially concerning because beneficiaries and providers rarely used the appeals process, which is designed to ensure access to care and payment. During 2014-16, beneficiaries and providers appealed only 1 percent of denials to the first level of appeal."

In addition to the numbers of overturned denials, persistent performance problems related to Medicare Advantage organizations were identified by CMS audits, according to the OIG. Investigators said one example is CMS citing 56 percent of audited contracts for making inappropriate denials in 2015. They said 45 percent of contracts were also cited for providing incomplete or incorrect information in denial letters.

The OIG recommended CMS step up oversight of Medicare Advantage contracts, "including those with extremely high overturn rates and/or low appeal rates and take corrective action as appropriate" and offer beneficiaries easily accessible information about serious violations by Medicare Advantage organizations. CMS agreed with the recommendations.

For more information please visit the following link: https://www.beckershospitalreview.com/finance/medicare-advantage-organizations-overturned-75-of-their-denials-fed-investigation-shows.html

Maximize Your Revenue

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