November – December 2016

NCDS update

A Billing Industry Newsletter for Clients

eeping your office up-to-date on industry and insurance changes, late-breaking billing & reimbursement news, and general inter-office communication…

PQRS – Are You Reporting?

Caleb Lamb – MingleAnalytics.com

It seems like the end of the 2015 PQRS reporting period wasn't that long ago, with registries concluding their submission process on March 31st. But we are now more than halfway through 2016 with the end of the service year in sight. CMS will begin accepting PQRS submissions after December 31st. With a PQRS registry's help, practices can start the reporting process and finish their submission any time before the March 31st, 2017 deadline.

It is now more important than ever to start the reporting process sooner rather than later in 2016. Here are several benefits practices and providers can take advantage of by starting the reporting process right now.

Beginning the PQRS reporting process right now allows you to spread out the work of reporting on a year's worth of data over many months, as opposed to just a couple of weeks. A proactive approach can keep staff members who are responsible for reporting from being overwhelmed by the sheer enormity of the task.

The number of patients required to be reported on for an Individual Measures submission can easily reach into the thousands. The level of effort required can catch practices off guard who simply weren't ready for that kind of volume. Spreading out the work eliminates the stress that comes with facing a short deadline.

Starting the PQRS submission process early also gives you the chance to uncover errors soon enough to have time to fix them before the reporting deadline. PQRS reporting can be a confusing process and misunderstandings can develop for providers or staff when it comes to exactly what documentation is required for a patient to "meet" a measure.

Perhaps there's confusion over exactly what a measure means when it refers to a standardized tool or a follow-up plan. Working on the submission early can root out these problems and allow you to change the way information is being documented so that the quality action is met for the rest of the year going forward.

Providers can face potential penalties even if they submit PQRS data effectively. Successful submissions are still subject to the Quality Tiering process, where practices are compared on cost and quality to other practices with successful PQRS submissions. Medicare calculates cost from the charges submitted by providers for patients attributed to the practice. Quality has two components: CMS calculated measures and PQRS measures.

https://mingleanalytics.com/4-benefits-starting-2016-pqrs-submission-right-now/

NCDS is prepared to assist you with the PQRS needs of your practice so you can continue to focus on what is most important – patient care and practicing medicine. Contact Nicolette Jordan at 888-876-8833 ext. 43 or nicolettej@ncdsinc.com to initiate your PQRS program today!

2017 Physician Fee Schedule Final Rule (MPFS) Sets Conversion Factor at $35.8887

The Centers for Medicare & Medicaid Services (CMS) has released the Medicare Physician Fee Schedule (MPFS) 2017 Final Rule, which sets the MPFS conversion factor at $35.8887 (up slightly from $35.8279 in 2016). The conversion factor accounts for a a budget neutrality adjustment of 1.0050, a 0.5 percent update factor required by MACRA, and a slight downward change due to the non-budget neutral 5 percent Multiple Procedure Payment Reduction (MPPR) for the professional component of imaging services. The coming year (2017) will be the first performance year for Merit-based Incentives Payment System (MIPS), as described in the U.S. Department of Health and Human Services (HHS) October 14, 2016 final rule. The MPFS final rule finalizes changes to align with the policies adopted for MIPS and Alternative Payment Models (APMs), and:

- finalizes a policy to streamline the quality validation audit process and, absent unusual circumstances, to use the results to modify an ACO's overall quality score;
- finalizes revisions to references to the Quality Performance Standard and Minimum Attainment Level;
- revises policies regarding the application of flat percentages to provide that measures calculated as ratios are excluded from use of flat percentages when such benchmarks appear "clustered" or "topped out";
- modifies Physicial Quality Report System (PQRS) alignment rules to permit flexibility for EPs to report quality data to PQRS to avoid the PQRS and VM downward adjustments for 2017 and 2018 in cases where an ACO fails to report on their behalf; updates the assignment methodology to include beneficiaries who identify ACO professionals as being responsible for coordinating their overall care.

CMS believes that chronic care management (CCM) services may be underutilized, and is proposing changes to increase utilization and to pay for CCM services for more complex patients.

CMS also expanded coverage for telehealth services including: End-stage renal disease (ESRD) related services for dialysis; advance care planning services; and critical care consultations furnished via telehealth using new Medicare G-codes. CMS "expect[s] these changes to increase access to care in rural areas, based on recent utilization of similar services already on the telehealth list, [CMS] estimate[s] no significant impact on PFS expenditures from the additions relative to overall PFS expenditures."

For more information: https://www.aapc.com/blog/36759-2017-physician-fee-schedule-final-rule-sets-conversion-factor-at-35-8887/?utm_medium=email&utm_campaign=Member&utm_source=_C-hbm_M-MM_D-11-21-16_P-hbm-news_T-hubspot&_hsenc=p2ANqtz-_fr5yHUQgaeeCJKISdX1THxBcZJ4vmb8fBeDu0Wm51i6uh_ka2tLwgce96X4TmXNYj9c0_elPTxRp2ljUdvFKyfyu2uw&_hsmi=37964206

Trump's Election: What Now for Healthcare?

Greg A. Hood, M.D. – www.Medscape.com

American voters have been angry for a long time. The seeds of discontent that finally boiled over in this election cycle have been simmering for years. Healthcare reform has been at the center of these feelings throughout President Obama's terms in office. Until the Republicans retook the White House and maintained control of the House and Senate, there was no path for substantively changing this expansive law and its even more extensive regulations. In a move that surprised all of the pollsters, most experts, and perhaps the majority of Americans, this is exactly what happened on the 8th of November. This was a notably unprecedented election result.

However, there are some precedents which the President-elect and GOP may do well to keep in mind if they start to craft their repeal-and-replace plans—notably the ACA's passage itself. Much anger was generated in the passage of the ACA because the Democrat super-majority led to a monstrously long bill being passed without a single Republican "aye" vote. Avoiding the appearance of strong-arming Obamacare repeal solely by the "unified Republican government," as House Speaker Paul Ryan recently referred to it, may be an important start towards quenching some of the heat and tension that this country currently feels.

A complete repeal of the ACA is not the same proposal that it once was, in spite of its "catastrophe" status, as assigned by the President-elect. This law and its regulations have, depending on your position, either transformed or metastasized through most every aspect of healthcare delivery. To resect it now is a very different prospect than it would have been 5 years ago.

We may find that discontent among the public, as well as within Organized Medicine, over the escalating cost of prescriptions, for example, is a very populist and more readily achieved goal than the wholesale, immediate replacement of the healthcare delivery system. Twice as many Americans were interested in this (74%) than in making repeal of Obamacare priority number one (37%).

The state exchanges that have failed or are failing were plainly financed for failure in their original design. The projected changes in premiums do create an urgency to address common-sense reforms. Additionally, the more that election-result uncertainty persists in the investment markets and in the healthcare industry, the greater the potential for negative economic consequences. This would be ill-timed, given high rates of provider disaffection with healthcare financing, board certification processes, the tort climate, electronic record keeping, the escalating costs of maintaining a practice, and other concerns. Prolonged uncertainty may have far-reaching repercussions.

Campaign rhetoric aside, we have no past performance data nor other means to gauge the expectations we should have for what he will actually try to do, and with what vigor. For now, we are watching a moment in history. This election result was a defiant act of anger, frustration, and, to an extent, hope. The current president may have assumed that hope would be enough. In 2016, hope may have sprung from another direction, but 2017 will dictate whether this wellspring will nourish the tree of liberty or wash away the hopes of those who wish to make America great again.

For the complete article please visit: http://www.medscape.com/viewarticle/871682#vp_1

Market Place Open Enrollment

Open Enrollment on the Health Insurance Marketplace began November 1, 2016, to enroll, re-enroll or change a plan for the upcoming year on the Marketplace. Open Enrollment runs until January 31, 2017 — remind your staff to request and verify insurance information for each patient, each visit, as incorrect insurance information is the primary source of rejected claims.

The last day to enroll or make a change in an existing plan is December 15, 2016 (for coverage effective January 1, 2017)

HSA Balances Climb But Benefits Reward Wealthier Consumers Most

Michelle Andrews – www.Khn.Org

President-elect Donald Trump has proposed expanding health savings accounts as an alternative to the health law. More than 20 million people now have high-deductible health plans that can link to the tax-advantaged accounts, and the average account balance grew by more than a third last year to more than $1,800, according to a new analysis. But consumer advocates warn that health savings accounts would do little to help lower income people who would lose their health insurance if the health law is repealed.

Since their introduction in 2004, health savings account plans have grown steadily. The health plans that link to HSAs have to meet federal standards, including having a deductible of at least $1,300 for single coverage and $2,600 for families in 2016 (the amount will remain the same in 2017).

Health savings accounts provide a triple tax advantage that's not available in other types of savings accounts: Money that's deposited in the accounts reduces taxable income, earnings in the accounts grow tax free and the money isn't taxed when it's used to pay for qualified medical expenses.

At the end of 2015, the average HSA balance was $1,844 — 38 percent higher than the average $1,332 balance at the beginning of the year, according to an analysis of 4 million accounts with $7.4 billion in assets by the Employee Benefit Research Institute. Eighty percent of the accounts with contributions last year also had payouts of an average $1,748.

"When people first have the health savings account, they just see it as a way to pay their medical expenses," said Paul Fronstin, director of the health research and education program at EBRI, who authored the analysis. "But then at some point they realize they can leave it in because it grows tax free." If people withdraw their account funds to use for non-medical expenses they'll be taxed on the income and may be assessed a 20 percent penalty.

But the tax advantages of HSAs skew heavily toward people with higher incomes, say policy experts. People whose income doesn't meet the income tax filing threshold — about $10,000 for one person or $20,000 for a couple — get no tax benefit at all, and those in lower tax brackets get less benefit from the tax deduction than those in higher income tax brackets. Trump's proposal is short on details, but Republicans have proposed a variety of HSA expansions, including raising the maximum contribution limits and expanding what the accounts can be used to pay for.

To read the full article please visit: http://khn.org/news/hsas-benefits-reward-wealthier-consumers-most/

Obama Urges the Public to Tell Republicans Not to 'Abandon' the ACA

Amy Goldstein – www.TheWashingtonPost.com

President Obama on Friday urged the American public to press the Republican-led Congress not to abandon gains in insurance coverage and access to health care that the Affordable Care Act has brought during the past six years.

The president's brief remarks, on Facebook Live in front of a White House fireplace with Christmas decorations, were his most pointed since last month's election about the fate of the health-care law that stands as the largest domestic achievement of his presidency — and a main target of President-elect Donald Trump and the Republican majority in Congress.

Obama spoke amid the fourth year's enrollment period for consumers to buy health plans through ACA marketplaces, created for people who cannot get affordable coverage through a job. "If you haven't gotten covered, now is the time to do it," the president said, noting that Dec. 15 is the deadline for people to have insurance at the start of 2017.

Trump has said that abolishing the ACA will be one of his first priorities. This week, he chose as his health secretary a vehement critic of the law. Obama administration officials have contended that a strong enrollment would demonstrate support for the law and act as a buffer against its repeal.

"Don't let Republicans in Congress" take away the ACA's most popular features, Obama said. "Tell them, 'We want to build on the progress we've made, not abandon it.' "

On Wednesday, federal health officials announced that, during the first four weeks of the three-month enrollment period, 2.1 million people have selected plans through HealthCare.gov, the ACA's federal insurance exchange, slightly ahead of a year ago.

https://www.washingtonpost.com/national/health-science/obama-urges-the-public-to-tell-republicans-not-to-abandon-the-aca/2016/12/02/5465acae-b8d6-11e6-959c-172c82123976_story.html?utm_term=.407aaa95dbad.

Buckeye Health Plan Offers a Better Way to Obtain Prior Authorizations

Bookmark and save this link on your office computers if your practice sees buckeye patients. The Medicare/Medicaid MCO and MyCare coverage provider has designed a website link to make it easier for providers to determine if a prior authorization is required and follow the steps to complete the process online.

https://www.buckeyehealthplan.com/providers/preauth-check.html

The step by step process lets you choose the type of coverage your patient has, then answer a few follow up questions to determine a Yes or No outcome if prior authorization is needed, taking you directly to the link to complete the process. With so many insurances pushing providers to their websites (versus telephone customer service or IVRs) we are hopeful and optimistic other carriers will follow suit. The design of Buckeye's site is easy, fast and user friendly; all of which are important to a busy physician's office!

Regulatory Alert – CMS Policies

HBMA GR Committee

Ignorance of the law (or CMS policy) is no excuse… CMS has provided additional guidance to physicians and other providers for determining when a Contractor shall assume a physician, provider, or supplier should have known about a policy or rule. Contractors shall assume the provider, physician, or supplier should have known about a policy or rule, if:

- The policy or rule is in the provider, physician, or supplier manual or in Federal regulations;
- The Centers for Medicare & Medicaid Services (CMS) or a CMS contractor provided general notice to the medical community concerning the policy or rule;
- CMS, a CMS contractor, or the Office of Inspector General (OIG) gave written notice of the policy or rule to the particular provider/physician/supplier;
- The provider, physician , or supplier was previously investigated or audited as a result of not following the policy or rule;
- The provider, physician , or supplier previously agreed to a Corporate Integrity Agreement as a result of not following the policy or rule;
- The provider, physician, or supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements which are related to the policy or rule; or
- The provider, physician, or supplier previously received documented training/outreach from CMS or one of its contractors related to the same policy or rule.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9708.pdf

GOP Lawmaker Outlines Goal to Repeal and Replace Obamacare

Nikita Vladimirov – www.TheHill.com

Sen. John Barrasso (R-Wyo.) on Saturday highlighted the Republicans' mission to repeal and replace ObamaCare during the weekly GOP address. Barrasso underscored the importance of "revers[ing] the damage done by ObamaCare" through a smooth transition. "In small towns and big cities across America, families have spent the past several years struggling under the health care law known as ObamaCare," Barrasso said.

"The result of the election gives all of us the opportunity to take back control of our health care. Americans can look forward to getting the care that they need, from a doctor they choose at lower cost," he added. The lawmaker stressed that the healthcare law should not merely be amended and that it must be repealed and replaced with better alternatives.

Barrasso promised that the process of repealing and replacing the law would mean eliminating the health insurance mandate in order to ensure "more freedom and flexibility" for businesses and individuals.

The senator also assured that "people with pre-existing conditions will be protected" throughout the transition.

"My wife, Bobbi, is a breast cancer survivor, so I understand as a doctor and as a husband how critical it is that people with pre-existing conditions not lose their insurance," he said.

In conclusion of his address, Barrasso said that the process of defeating ObamaCare "won't be easy, and it's going to take some time," echoing other Republicans who have warned of potential obstacles they face, even with control of Congress and the White House.

For the complete article please visit: http://thehill.com/policy/healthcare/308608-gop-lawmaker-outlines-goal-to-repeal-and-replace-obamacare

Maximize Your Revenue

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