March – April 2019

NCDS update

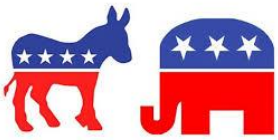
A Billing Industry Newsletter for Clients

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

Congressional Panel: Consumers Shouldn't Have To Solve Surprise Medical Bill Problem

Rachel Bluth – NPR.org

One point drew clear agreement Tuesday during a House subcommittee hearing: When it comes to the problem of surprise medical bills, the solution must protect patients — not demand that they be great negotiators.



"It is the providers and insurers, not patients, who should bear the burden of settling on a fair payment," said Frederick Isasi, the executive director of Families USA. He was one of the witnesses who testified before the House Health, Employment, Labor and Pensions Subcommittee of the Education & Labor Committee.

Surprise, or "balance," bills happen when patients go to a hospital they think is in their insurance network, but are then seen by a doctor or specialist who isn't. The patient is then on the hook for an often very high bill — sometimes exceeding thousands or even tens of thousands of dollars.

Stories in the Bill of the Month series by NPR and Kaiser Health News have drawn attention to the problem.

Surprise billing is one of the rare public policy problems that are both bipartisan and in need of a federal solution. Around 60 percent of people are covered by employer-sponsored insurance, which is regulated by the federal government, and aren't protected by the nearly two dozen state laws governing balance billing.

NCDS Perspective: This article provides valuable insight into the type of problem this legislation seeks to resolve and it will be interesting to follow the proposed resolutions. Uniquely, all insurance companies have the ability to select which providers it allows into their network. Providers often enroll in all carriers only to be told by some that the "panel is closed." In contrast, when providers do their rounds each patient is provided care regardless of personal circumstance, insurance network, etc. It is our hope this legislation produces greater accountability on the part of the insurance carriers. Requiring insurances to enroll eligible providers in a timely fashion at a fair rate of reimbursement would effectively prevent these "surprise bills" from ever generating at the provider level.

For the full article visit: https://www.npr.org/sections/health-shots/2019/04/02/709201186/congressional-panel-consumers-shouldnt-have-to-solve-surprise-medical-bill-probl

MMOH Updates Prior Authorization Policy Process

Beginning June 1, 2019 Medical Mutual will require that all prior authorizations for medical services be submitted through **NaviNet**. The only exceptions are for medical drug, radiology, chiropractic services as well as physical, occupational and speech therapies. Medical Mutual will no longer accept authorizations by fax or by phone.

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Register Today! If your office is NOT registered on NaviNet, please be sure to register today for this free tool. Click here for additional information specific to Medical Mutual: http://support.navinet.net/health-plans/medical-mutual-of-ohio

ACA Fight Leaves Out Healthcare's Problem, Politico Report Says

Morgan Haefner – BeckersHospitalReview.com

Partisan feuds surrounding the ACA have largely left out conversations about the large medical bills families and individuals face, according to *Politico*.

Multiple recent polls have revealed that healthcare costs are the leading concern among American voters. Still, many political conversations about healthcare have revolved around protecting individuals with preexisting conditions and how to make health insurance more affordable, according to the report.

Senate Health, Education, Labor and Pensions Committee chair Lamar Alexander, R-Tenn., has tapped healthcare professionals and think tanks in an attempt to shift the ACA's debate toward cost. In a December 2018 letter, Mr. Alexander wrote, "The hard truth is that we will never get the cost of health insurance down until we get the cost of healthcare down."

As Democrats aim to improve the ACA with more subsidies and cost-shifting to taxpayers, and as Republicans create lower-cost alternatives to the 2010 health law, *Politico* says, "Neither approach gets at the underlying problem — reducing costs for both ordinary people and the healthcare burden on the overall U.S. economy."

https://www.beckershospitalreview.com/finance/aca-fight-leaves-out-healthcare-s-cost-problem-politico-report-says.html

RCM Tip of the Day: Talk To Patients About Billing Before Service

Kelly Gooch – BeckersHospitalReview.com

As patients become more involved in the financial aspects of their care, hospitals and health systems should focus on getting self-pay patients involved before their service, advised Marty Callahan, president of healthcare markets for RevSpring, a revenue cycle management company.

"Patients engaged throughout the service delivery cycle are more likely to participate fully in payment processes. Taking a lead from consumer-focused industries, healthcare organizations should open up the lines of communication about billing and payment options prior to treatment to help patients prepare financially for any forthcoming charges," he said.

"Patients often report a more positive billing experience when an estimate of services is delivered up front. Pre-service patient communication eliminates the surprise of out-of-service costs and can even help drive improvements in financial results for the organization," Mr. Callahan said.

Mr. Callahan also said comprehensive patient communication platforms can help hospitals and health systems provide the necessary patient outreach and education throughout the care journey.

https://www.beckershospitalreview.com/finance/rcm-tip-of-the-day-talk-to-patients-about-billing-before-service.html

HIPAA Violation Leads to Criminal Conviction of Former Patient Coordinator

Kreig DeVault – Lexology.com

A former Patient Information Coordinator (Patient Coordinator), previously employed with UPMC and its affiliate, Tri Rivers Musculoskeletal Centers (TRMC) in Mars, Pennsylvania, pleaded guilty to a charge of wrongfully disclosing health information, in violation of the Health Insurance Portability and Accountability Act (HIPAA). The FBI led the investigation that revealed the Patient Coordinator improperly accessed the individual health information of 111 UPMC patients who had not received services at TRMC. Additionally, the investigation uncovered that the Patient Coordinator unlawfully disclosed personal gynecological health information related to two such patients, "with the intent to cause those individuals embarrassment and mental distress."

It is rare that a HIPAA violation leads to criminal prosecution and should serve as a warning to facility employees with access to protected health information who might be tempted to violate HIPAA for nefarious reasons. The Patient Coordinator could face up to 10 years in prison, a fine of $250,000, or both for violating HIPAA laws.

For more information on this story please click the link below:
https://www.lexology.com/library/detail.aspx?g=46c89762-f5b7-4e47-97f3-8fd29b28e323

How Convenience is Reshaping Local Healthcare

Kaitlin Schroeder – DaytonDailyNews.com

Patient demand for convenience is reshaping local health care. Patients are setting up appointments online and visiting with providers over video chat, while primary care doctors are navigating a medical landscape with more competing walk-in options such as urgent care centers and grocery store clinics with increased services.

"It is dramatically changing what we do, there's no doubt about it," said Ted Inman, CEO of PriMed Physician, a physician-owned group based in Dayton. "We're having to invest in more and more technology, but at the end of day it typically is cheaper, you just need to go through the process to get there."

Demand for convenience has fueled more on-demand health care options, mirroring trends in other industries such as the rise of grocery delivery and online shopping.

The number of retail clinics in the U.S. grew from around 1,400 to 2,800 between 2012 and 2015, according to research firm Accenture. And there are about 8,700 urgent cares in the U.S., up from 6,400 in 2014, according to the Urgent Care Association. New technology has enabled the sweeping changes and led to industry disruption.

Several insurance companies have launched their own telemedicine initiatives for their members to video chat with in-house providers. In addition, some health care startups are also looking to grab marketshare from traditional health care players by pushing their convenience, such as apps that let you get birth control prescribed over your phone and home delivered.

Inman said they navigate the demand for convenience means steps like having on-call nurses, having pediatric offices with late hours and same day appointments for pediatrics. PriMed plans to invest in some type of e-visiting technology, but is still working on the timing of the change, which would mean a sizable IT investment.

It also means primary care providers making a case for their distinct value, such as a long-term relationship and wellness visits instead of episodic visits for illness with a different provider each time.

"They don't have your medical records. We have the convenience of always having your medical records right there," said Dawn Kerr, regional operations manager for Providence Medical Group, which started video visits in 2017.

What's convenient for patients, however, might not always be convenient for doctors. Keeping up with the flexibility of an express clinic or the convenience of an insurer's video chat service can mean providers working later or differently, and also can mean a large upfront technology investment for practices.

Inman said it's a balancing act that requires working with providers and becoming more flexible and consumer driven. Ultimately, he said some of these changes should help save practices time. Patients setting up their own appointments online or having digital access to health care information can save doctors from phone calls.

Inman said some patients might end up in the wrong setting for the type of treatment they need because it is the most convenient setting. When practices have convenient options, such as online visits, he said the convenience can also mean a patient being able to be seen who might not have otherwise.

"If someone can be seen as opposed to not or at least have contact as opposed to not, the chances are that they aren't going to end up inappropriately in the emergency department which is the highest cost place of care," Inman said.

For the complete article please visit:
https://www.daytondailynews.com/business/how-convenience-reshaping-local-health-care/Q0zgiUqrOQdA90rZ2ZcZWL/

BCBS of Texas to Open Primary Care Clinics: 5 Things to Know

Morgan Haefner – BeckersHospitalReview.com

Blue Cross and Blue Shield of Texas will open 10 advanced primary care medical centers in Dallas and Houston under a partnership with global primary care provider Sanitas.

Five things to know:

1. The clinics will open Jan. 1, 2020.
2. Services such as primary care, urgent care, lab and diagnostic imaging, care coordination, and disease management programs will be available at the medical centers.
3. Some of the medical centers will be open every day during the year, and every clinic will have longer weekday and weekend hours.
4. BCBS members, self-pay patients and Medicare recipients will be able to access the medical centers.
5. Dan McCoy, MD, president of BCBSTX, said in a prepared statement, "We believe that this partnership will advance primary care services and is an effective approach to providing quality healthcare outcomes, improving member engagement and experience, and lowering costs for our members, including populations that may have difficulty accessing care."

https://www.beckershospitalreview.com/payer-issues/bcbs-of-texas-to-open-primary-care-clinics-5-things-to-know.html

What Did the Apple Heart Study Really Find?

Milton Packer MD – BeckersHospitalReview.com

Six months ago I wondered if the new Apple Watch was the worst heart device ever. Some readers may have thought I was exaggerating. But based on the results of the Apple Heart Study -- which were released at the American College of Cardiology meeting this week -- it is now official. The Apple Watch is a serious competitor for the worst heart device ever.

What was the Apple Heart Study? It was one of the largest studies of "digital health" to date. Nearly 420,000 people throughout the U.S. agreed to participate. The participants wore watches that sent intermittent information about the regularity of their heart rhythm to Apple for varying periods of time. During the study, about 2,100 notifications of a heart "irregularity" were sent.

Did the Apple Watch detect any serious cardiac arrhythmias in a meaningful number of people? A majority (219,179, 52%) of the people in the study were under age 40. Among those people, a mere 341 (0.16%) were notified of an "irregularity," and of these, only nine (0.004%) actually had atrial fibrillation.

What were the results in elderly people? Of 24,626 people ages 65 or older, 3.14% were notified of an "irregularity," and of these, only 63 people (0.26%) actually had atrial fibrillation. But the device sent an alert to 775 people! Overall, the chances of the Apple Watch detecting undiagnosed atrial fibrillation in this study were lower than the chance of a person being struck by lightning during their lifetime (0.03%)!

But an analysis by Venk Murthy, MD, PhD, of the University of Michigan, suggests that the Apple device failed to correctly identify atrial fibrillation in a large proportion of people who actually had it.

For the complete article please visit:
https://www.medpagetoday.com/blogs/revolutionandrevelation/78684

Death by 1,000 Clicks: Where Electronic Health Records Went Wrong

Fred Schulte and Erika Fry, Fortune via CaliforniaHealthline.org

The pain radiated from the top of Annette Monachelli's head, and it got worse when she changed positions. It didn't feel like her usual migraine. The 47-year-old Vermont attorney turned innkeeper visited her local doctor at the Stowe Family Practice twice about the problem in late November 2012, but got little relief.

Two months later, Monachelli was dead of a brain aneurysm, a condition that, despite the symptoms and the appointments, had never been tested for or diagnosed until she turned up in the emergency room days before her death.

Monachelli's husband sued Stowe, the federally qualified health center the physician worked for. Owen Foster, a newly hired assistant U.S. attorney with the District of Vermont, was assigned to defend the government. Though it looked to be a standard medical malpractice case, Foster was on the cusp of discovering something much bigger — what his boss, U.S. Attorney Christina Nolan, calls the "frontier of health care fraud" — and prosecuting a first-of-its-kind case that landed the largest-ever financial recovery in Vermont's history.

Foster began with Monachelli's medical records, which offered a puzzle. Her doctor had considered the possibility of an aneurysm and, to rule it out, had ordered a head scan through the clinic's software system, the government alleged in court filings. The test, in theory, would have caught the bleeding in Monachelli's brain. But the order never made it to the lab; it had never been transmitted.

The software in question was an electronic health records system, or EHR, made by eClinicalWorks (eCW), one of the leading sellers of record-keeping software for physicians in America, currently used by 850,000 health professionals in the U.S. It didn't take long for Foster to assemble a dossier of troubling reports — Better Business Bureau complaints, issues flagged on an eCW user board, and legal cases filed around the country — suggesting the company's technology didn't work quite the way it said it did.

Until this point, Foster, like most Americans, knew next to nothing about electronic medical records, but he was quickly amassing clues that eCW's software had major problems — some of which put patients, like Annette Monachelli, at risk.

Damning evidence came from a whistleblower claim filed in 2011 against the company. Brendan Delaney, a British cop turned EHR expert, was hired in 2010 by New York City to work on the eCW implementation at Rikers Island, a jail complex that then had more than 100,000 inmates. But soon after he was hired, Delaney noticed scores of troubling problems with the system, which became the basis for his lawsuit. The patient medication lists weren't reliable; prescribed drugs would not show up, while discontinued drugs would appear as current, according to the complaint. The EHR would sometimes display one patient's medication profile accompanied by the physician's note for a different patient, making it easy to misdiagnose or prescribe a drug to the wrong individual. Prescriptions, some 30,000 of them in 2010, lacked proper start and stop dates, introducing the opportunity for under- or overmedication.

For the complete article please visit:
https://californiahealthline.org/news/death-by-a-thousand-clicks/

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