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2015 Fourth Quarterly Newsletter

ICD-10 IMPLEMENTATION

After a few delays, the ICD-10 mandate has finally arrived. This has been a major change and the talk of the healthcare industry. It has also lead to changes in how business is done in an office; examples include training for billers, coders, and office staff to adapt to new coding changes, investments in new software, and clearinghouse relationships that are able to guarantee compliance to the new coding system, among many other factors affecting the industry as a whole. Going into effect October 1st, all covered healthcare entities (which include individual physicians, group entities like hospitals and long term care facilities, clearinghouses, and insurance carriers) must report and process claims with the new set of diagnosis codes. ICD-9 codes, in use since the 1980s, will no longer be accepted on claims with a date of service on or after October 1st, 2015. ICD-9 can still be used after the implementation date in two circumstances:

⇒ Claims with a DOS before October 1st, 2015

⇒ A workers compensation or no-fault insurance request for diagnosis codes to be in ICD-9 (while these are insurance companies, they are not considered covered entities by CMS - it is encouraged for these companies to follow the ICD-10 mandate, but not required)

It is important not to overlap the two different sets of diagnosis codes when it comes to billing for your services. While insurance companies will be able to process claims billed under either code set, make sure your billing and coding staff are aware of the following:

⇒ ICD-9 diagnosis codes should only be used for services rendered before October 1st. 2015. Do not report ICD-10 codes on these claims

⇒ ICD-10 diagnosis codes should only be used for services rendered on or after October 1st, 2015- the only time a ICD-9 code can be reported on these bills is for a non-covered entity such as a NF or WC carrier

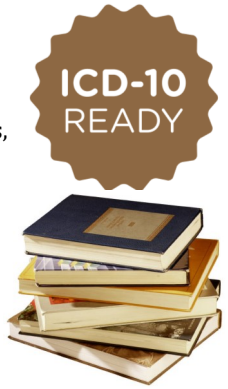
⇒ If a claim is billed for multiple DOS (such as subsequent hospital care, or staged procedures) that overlap the ICD-10 transition, the claims must be split for proper processing since the different diagnosis codes cannot be reported on the same electronic or paper claim

In addition to all of the changes in claim preparation and submission, physicians should also make sure to review LCD policies from Medicare and any applicable guidelines from the commercial insurances that are accepted. All Medicare carriers will be re-publishing LCD policies with an effective date of October 1st for all of the medically necessary coding for ICD-10. Commercial insurance companies, such as Aetna, Cigna, Blue Cross, and United Healthcare have been publishing medical policies with ICD-10 codes prior to the implementation date for providers to prepare for diagnosis codes that meet medical necessity requirements for particular services. If the documentation is unclear, outdated, or unavailable to determine if coding is valid for particular services, contact the benefit department of the insurance company to verify before submitting claims for processing.

ONE YEAR FORGIVENESS PERIOD

In an effort to address provider concerns, CMS and AMA have announced additional guidance to help with the transition. Along with educational webinars, on-site training and educational articles, CMS has announced that they will allow for flexibility in the claims auditing and quality reporting process. For a period of 12 months following the implementation of ICD-10, Medicare contractors **will not deny** physician claims billed under PART B schedule (through automated or complex medical record review) based *solely* on the specificity of the ICD-10 diagnosis code as long as the provider used a valid code from the right family. This policy will be adopted by the Medicare Administrative Contractors, the Recovery Audit Contractors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

The same will apply to the diagnosis codes used for PQRS or MU reporting purposes, however, here again the provider must use a diagnosis for the correct family of codes.



Keep in mind, that while Medicare has this leniency with coding, other insurances, such as Medicare advantage plans, secondary insurances, Medicaid, and commercial insurances are not required to follow these guidelines. Providers who elect to code to the lower level of specificity may not be paid for the Medicare deductible or co-insurance because the claims are not coded to the highest level of specificity. In these cases, patients cannot be billed for any balance because proper coding is the responsibility of the physician submitting the claim.

For further information please refer to CMS link below:

http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10/

Don't like ICD-10? Don't worry….ICD-11 is on the way!!! The World Health Organization (WHO) is set to release the new code set in 2018 with a projected implementation date of 2023. An ICD-11 beta draft is available through the WHO website.

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ANTHEM CIGNA MERGER

Anthem Health Insurance revealed on July 24, 2015 that it has reached a deal to acquire Cigna. Under the proposed terms of the deal Anthem shareholders would own 67% of the combined company while Cigna shareholders would own the remaining 33%. Anthem expects to finalize this purchase in the second half of 2016.

This new deal came on the heels of another mega merger as Aetna acquired Humana earlier in July. If both deals pass state regulatory approvals and other requirements, the insurance industry would only leave three major players with UnitedHealth being the third.

Health insurers are seeking to consolidate in order to reduce costs and improve efficiencies and the Affordable Care Act has been a driving force as more Americans have health coverage. Obamacare has forced greater transparency in pricing and less generous funding of government plans, putting more pressure on industry profits. The question remains as to whether the cost reduction to the health insurers will benefit the consumer or will it simply increase the value for the shareholders.

The concern for healthcare providers is even greater as the mergers mean increased leverage and greater clout in negotiating rates with hospitals and physicians.

OON/BALANCE BILLING

It is a violation of Stark Law for any provider, whether in-network or out-of-network with an insurance plan, not to follow protocol when balance billing patients. While waiving a portion of a medical bill may seem like a generous gesture, you **must** bill the patient even if there is no contractual obligation with the insurance plan. Failure to bill patients for their responsibility will have consequences.

Rules are clear when a provider participates with an insurance plan - contracts specify that:

⇒ Any co-pays must be collected at the time of service

⇒ A patient is responsible for their deductible and/or co-insurance after a claim has been processed

⇒ A patient may not be balance billed for any amount considered a contractual write off

While it may not seem like there are rules that come into consideration with insurances that are *not* accepted in your practice, general guidelines exist that must be followed, such as:

⇒ If the plan makes payment at the OON rate of reimbursement, providers are expected to collect any patient responsibility as outlined by the insurance company applied to the OON deductible and/or co-insurance

⇒ If no payment is made and the entire amount is applied to patient responsibility as a non-covered service, the patient should receive a bill for the services provided

⇒ Co-pays should still be collected at the time of service

⇒ Insurance companies should be contacted for pre-certification prior to rendering services

⇒ Patients enrolled in Medicaid (or Medicaid managed care plans) may not be balanced billed

If an insurance company is notified that your practice has been giving financial incentives to patients by reducing their patient responsibility or billing members incorrectly, regardless of participation status, there will be penalties such as recoupments, payment adjustments, possible reduction in the fee schedule, and sanctions for government programs. There are extreme cases where waiving patient responsibility is acceptable as long as there is proof of a patient being financially incapable of paying for the balance, or that collection efforts have been made in good faith before writing off any balance. In the absence of the above, all providers are obligated to follow set rules and guidelines outlined by the patient's plan.

WOUND CARE

Whenever an ulcer or a wound is treated and/or debrided; Medicare, Medicare Advantage plans, and commercial carriers expect certain documentation to be present. Your medical record should include the following information (extracted from NGS LCD policy L33614):

⇒ An operative note or procedure note for the debridement service. This note should describe the anatomical location treated, the instruments used, anesthesia used if required, the type of tissue removed from the wound, the depth and area of the wound and the immediate post procedure care and follow-up instructions.

⇒ Identification of the wound location, size, depth and stage either by description and/or a drawing or photograph.

⇒ A description of the type(s) of tissue involvement, the severity of tissue destruction, undermining or tunneling, necrosis, infection or evidence of reduced circulation. If infection has developed, the patient's response to this infection should be described.

⇒ The patient's comorbid medical and mental condition, and all health factors that may influence the patient's ability to heal tissue, such as, but not limited to the following: mental status, mobility, infection, tissue oxygenation, chronic pressure, arterial insufficiency/ small vessel ischemia, venous stasis, edema, type of dressing, chronic illness such as diabetes mellitus, uremia, COPD, malnutrition, CHF, anemia, iron deficiency, and immune deficiency disorders.

⇒ A determination of the initial treatment plan to include the expected frequency and duration of the skilled treatment and the potential to heal. Continuation of treatment plan with ongoing evidence of the effectiveness of that plan, including diminishing area and depth of the ulceration, resolution of surrounding erythema and /or wound exudates, decreasing symptomatology, and overall assessment of wound status (such as stable, improved, worsening, etc.). Appropriate changes in the ongoing treatment plan to reflect the clinical presentation must be present in the record.

⇒ The documentation must include that if indicated, ongoing pressure relief has been prescribed, for example, shoe inserts, modifications, padding, frequent position changes, etc. and monitoring is occurring.

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2015 MEANINGFUL USE FINAL RULING

On October 6th, CMS released the long awaited final rule that encompasses 2015 through 2017 reporting (Modified Stage 2) and Stage 3 in 2018 and beyond.

As initially proposed, the rule shortens the 2015 reporting period to any continuous 90 days from January 2015 to December 2015.

The rule also changed one of the most contested measures: **Stage 2 Electronic Access**, Measure 2. For 2015, instead of the previous 5 percent threshold, this measure now requires that at least **one** patient seen during the reporting period, views, downloads or transmits his or her health information. **Stage 2 Secure Electronic Messaging** has been reduced to an attestation that the capability for patients to send or receive a secure message was fully enabled during the reporting period.

For further information on this ruling please see:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2015ProgramRequirements.html

MEANINGFUL USE

EHR (electronic health records) has been a point of discussion for all provider types for the past several years - the use of this technology would allow practitioners to move away from paper documentation to a system where multiple independent doctors of facilities can exchange information to decrease costs and benefit patients. CMS has been advocating for the benefits of EHR for some time. There were incentives given to healthcare providers who met minimum criteria that implemented use of this technology in its early stages, back in 2011. With its importance being bolstered by the Affordable Care Act, the incentives that were once available have now turned into penalties if a practice or facility does not take the appropriate steps to use EHR. Starting in 2015, providers who have not successfully attested to being a meaningful use will be subject to a 1% decrease in Medicare payment. For every year following 2015 that a provider does not become a meaningful user, the reduction will get higher, increasing one percent every year to a cap of 5% in 2020 for providers who are still not successful users of this software. Below are steps that should be taken to make sure that there is no reduction in your Medicare payments:

⇒ Confirm that your CEHRT (certified electronic medical records technology) is fully updated and approved by CMS

⇒ Owning the software is not enough - the technology must be implemented in your practice's workflow to meet reporting criteria relevant to your office or specialty

⇒ Make sure the appropriate number of measures are reported, whether a stage 1 or stage 2 user in meaningful use

⇒ Data must be reported for a full year to CMS. Double check to make sure there is no interruption in attesting measures and other requirements to CMS

⇒ Retain backups and proofs of data submission in the event that an audit is conducted by CMS to verify the integrity of the information submitted

Resources:
www.cms.gov, www.who.org, www.hrsa.gov, www.medicaid.gov

MEDICAID HMOs

Medicaid (the payer of last resort) is a program offered in all states for individuals who cannot afford health insurance, are disabled, or who meet other eligibility criteria. With Obamacare mandating that all citizens must have health insurance, more patients are becoming eligible for free or state subsidized healthcare making Medicaid a much more common occurrence in your office. For most states, when patients elect Medicaid coverage, they are enrolled in a managed care plan (HMO) that is responsible for administering their benefits on behalf of the state. In the past, these HMOs only serviced part of the Medicaid population, such as children enrolled in CHIP; most other groups were enrolled in traditional Medicaid. However, these groups now are being required to choose an HMO that will be responsible for their benefits. This holds true even for adults and senior citizens that have Medicare or private insurance as primary. It is crucial, whether a patient provides Medicaid as their only insurance or as secondary, that benefits are checked thoroughly with a website or automated system to confirm what HMO they are enrolled in. If a claim is submitted to traditional Medicaid when a patient is enrolled in an HMO, the claim will not be paid stating that the patient is enrolled in managed care- keep in mind, a majority of HMOs have short timely filing limits of 90 days from the DOS. In addition, just because a provider or practice is participating with Medicaid does not mean that they are in network with all Medicaid managed care plans- verify participation with all local plans to prevent excessive denials for services that were not authorized by the HMO.

As a reminder, under no circumstances can a provider bill a patient for services if they are Medicaid eligible on the DOS, they cannot be legally billed for any services, whether or not the services are covered by Medicaid. There are only two acceptable circumstances where a provider can balance bill a patient for any outstanding balance:

- Confirmation that a patient was not Medicaid eligible on the DOS

- Patient is enrolled in a limited benefit package that only covers specified services (such as family planning)

Providers should also keep in mind that if there is any balance from Medicare or a commercial insurance as their co-pay or co-insurance, the balance will have to be written off in most cases because the amount paid by Medicare or other insurance is greater than the Medicaid allowable amount (to reiterate, the patient cannot be balance billed for this not covered amount, whether or not the provider participates with Medicaid. Deductibles will be covered, but only up to the allowed amount of the Medicaid program, minus any partial payments made by the primary insurance carrier.)