THE LEADING EDGE

SUMMER 2015 ISSUE

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THE LEADING EDGE

Welcome!

Welcome to the Summer 2015 edition of the Leading Edge. We have a reprise of the highly anticipated "King vs. Burwell" Supreme Court ruling. Like many, we anticipated that a different outcome would have wide repercussions. Fortunately for many consumers, providers and insurers, that isn't the case.

While on the ACA, our next feature highlights the "Cadillac Tax." Many hospitals, physician groups and other employers are likely to be impacted directly by this 40% excise tax on healthcare premiums above the thresholds. Expect to hear a lot more before the tax goes into effect in 2018.

In "Keeping the Emergency Room Healthy," we see how ER usage continues to increase despite the expectation that more insureds would use other settings for non-emergency care. Many are concerned that too much of an increase in non-urgent care could be detrimental to care for those who are critically injured or need immediate emergency care. And Alternative Payment Models, over the longer term, may financially harm emergency departments by sending care elsewhere.

With all of the pressure to reduce imaging for both cost and radiation exposure reasons, a recent ACR study is reassuring. It shows that most ER imaging is done consistent with ACR guidelines

How to handle an incidental finding that occurs during an emergency department visit? This question arises frequently. With effort, radiology and emergency departments can significantly reduce communication barriers for patients who require follow-up care upon discharge.

Our Medicare feature shows how Medicare is, by historical standards, very recent. And issues such as concerns about costs and reimbursement are even more recent.

The next feature summarizes our annual client survey. The punchline: our clients expect results and service. That is really not a surprise. But it does reinforce the relevance of our client promises: More Money, Faster and ClientFirst Service.

With ICD-10 now only 4 months away, in AdvantEdge News we update our ICD-10 implementation plans. And we continue our ICD-9/10 comparisons with "Open Wound of Elbow, Forearm and Wrist."

A reminder that you can print or email any article as a PDF. Plus the "Download Current Issue" choice at top right downloads the entire newsletter for email or printing.

Please call or email me with comments and suggested topics for the next issue: bgilbert@ahsrcm.com and (908) 279-8120.

Bill Gilbert

Keeping the Emergency Department Healthy

For years, emergency departments (EDs) have been used by low income, Medicaid, and non-insured patients for medical care, regardless of whether their symptoms required emergency intervention. And, EDs have been profiled as one of the largest cost centers in health care. With the expansion of insurance coverage to the non-insured, along with the expansion of Medicaid coverage under the Affordable Care Act (ACA), it was expected that costly visits to the emergency department would be reduced as these newly insureds would now visit primary care physicians and clinics.

However, critics of the ACA predicted the opposite; that emergency room visits would increase due to Medicaid expansion and those newly insured who were unfamiliar with moving through the health care system.

Who was right?

According to a recent survey of more than 2,000 emergency physicians by the American College of Emergency Physicians (ACEP), "three-quarters of them reported that emergency department (ED) use experienced a significant increase over last year, a marked increase from a 2014 version of the same poll, in which half of the respondents identified an increase." The survey found:

- More than one-quarter (28 percent) of those surveyed reported significant increases in all emergency patients since the requirement to have health insurance took effect.
- 56 percent stated the number of Medicaid patients is increasing.
- About 90 percent reported the severity of illness or injury among emergency patients has either increased (44 percent) or remained the same (42 percent).

Since the original Marketplace open enrollment period began in October 2013, among the 49 states reporting both February 2015 enrollment data and data from July-September of 2013, over 11.7 million additional individuals are enrolled in Medicaid and CHIP. This is a 20.3 percent increase over the average monthly enrollment for July through September of 2013. (Connecticut and Maine are not included in this count.)[1]

The ACEP report also stated that ED leaders blame, in part, the increase in ER use on a lack of more appropriate places for non-urgent care patients to receive care. They believe the plans designed by policymakers and health insurance plans to reduce Medicaid patient use of the ER are not working, citing that more than half of providers listed by Medicaid managed care plans could not offer appointments to enrollees, despite the increasing pay to primary care physicians authorized by the ACA. The median wait time was 2 weeks but over one-quarter of providers had wait times of more than a month for an appointment.[2]

Thus, business is up in the ED, but many are concerned that too much of an increase in non-urgent care could be detrimental to the care of those who are critically injured or need immediate emergency care. The increase in patients also puts strains on ED staff trying to accommodate everyone who presents to the ER and more Medicaid patients at lower Medicaid rates, may increase the financial strains on some hospitals and emergency departments.

The Effect of Alternative Payment Models

Perhaps it is too soon to see the promised reduced usage of the emergency room as intended by the ACA. The savior was to be the alternative payment model. APMs are designed to shift payment away from "volume and intensity to moving toward providing a per-case or per-person payment" and to encourage the support of non-ED physicians to take steps to avoid ED utilization and inpatient admissions.[3]

However, some worry that in the future, these APMs may financially harm emergency departments by sending care elsewhere, which could have significant consequences for the quality of emergency care if APMs result in fewer net resources for EDs. [4]

It is well-known that the emergency room is the best place to handle three important roles in the healthcare system:

- 24/7 care for the sick and injured, particularly critical illness and injury such as trauma, stroke, etc., and they are the only game in town that stays open 24 hours a day,
- Capacity to respond to public health emergencies, disasters and terrorism, and
- Treatment of patients who need acute care regardless of whether they can pay (Emergency departments are required under a federal mandate to treat everyone, regardless of ability to pay).

The first two are natural fits for the ED and should always be available to the public. More than likely, other locations performing medical care would not threaten to take these patients away from the ED. Where the ED could be threatened would be its third role – treatment of patients who need acute care.

In a HealthAffairs report published in 2010, only 42 percent of the 354 million annual visits for acute care—treatment for newly arising health problems—are made to patients' personal physicians. The rest are made to emergency departments (28 percent), specialists (20 percent), or outpatient departments (7 percent). Although fewer than 5 percent of doctors are emergency physicians, they handle a quarter of all acute care encounters and more than half of such visits by the uninsured. [5]

With such a high volume of acute care encounters being performed in EDs, it is not yet clear how these visits will fit into the new payment models. Payment and delivery reform efforts must support needed improvements in acute care while at the same time assuring adequate support for needed urgent care in the ER. However, this would probably mean shifting acute care to primary care providers or community health centers, leaving EDs with fewer resources to care for the more complex patient population.

So far, there are no new payment models that focus on ED care, and only recently has there been mention of plans to broadly address ED-specific quality through new measurement programs. In December 2014, the National Quality Forum (NQF) released Phase 3 of their endorsed measures for Care Coordination, which proposed five new measures that would directly affect care in the emergency room, particularly transition of care to other locations.

For the ER to survive, payment reform must encourage more appropriate ED use, better care coordination, and more effective and efficient care for ED patients without being destructive to the critical emergency care functions that EDs provide to their communities. In doing so,

payment reform should consider:

- Reducing demand for ED care without reducing support for critical ED functions,
- Enabling healthcare organizations to support ED providers in their efforts to deliver effective patient care,
- Increasing the efficiency of ED care without placing patients at undue risk.

Without specific ED payment reform models, hospitals and emergency departments are experimenting with alternative ways of providing care in the ED while reducing costs. HealthAffairs Blog recently reported on how three medical centers instituted acute care-focused payment reforms that, so far, have led to improved value and higher quality care for EDs. What the article didn't address were the financial implications for emergency departments as these reform measures have initially decreased ED visits.

On May 6, the Richard Merkin Initiative on Payment Reform and Clinical Leadership convened medical and health policy experts to examine strategies that reduce ED system inefficiencies while preserving the best features of emergency medicine. One of the segments centered on payment for ED services as they move to policy reforms that support integration and transformation in the acute care setting. The panelists agreed that "financial alignment among payers, providers, and health entities is essential to ensure connectivity and coordination between EDs, specialists, governments, and authorities and that alternative payment models should be used to reimburse physicians as well as for hospitals to reward specialists, primary care clinicians, and emergency physicians for working together."

One of the ways to do this is for emergency departments and physicians to participate in developing acute care payment model pilots through the Center for Medicare and Medicaid Innovation (CMMI) and private payer initiatives to reward ED providers for the value they provide through the new services and delivery efficiencies.

Analysts say that the trend of rising ED visits across the nation will continue until the newly insured become more familiar with the health care process, there is an increase in primary care providers, and APMs become more prevalent. In the meantime, it will be important for EDs and their physicians to promote their expertise and efficiency in providing and transitioning patient care and being paid appropriately for it, particularly if ED visits begin to decline. ED providers must engage in reform and integrate themselves into the new payment models to ensure they remain healthy.

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[1] Medicaid & CHIP: February 2015 Monthly Applications, Eligibility Determinations and Enrollment Report, *The Centers for Medicare and Medicaid*, May 1, 2015 Report.
[2] American College of Emergency Physicians, "ER Visits Continue to Rise since Implementation of the Affordable Care Act," May 4, 2015.
[3] Pines, Jesse M., et al, "Can Payment Reform Improve Emergency Care?," *MedPage*, April 28, 2015.
[4] Ibid
[5] Pitts, Stephen R., et al, "Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office" HealthAffairs, September 2010.

How to Communicate Incidental Findings?

Coordinating Radiology and Emergency Department Communications

How do you handle an incidental finding that occurs during an emergency department visit? This question has plagued emergency departments and radiology departments alike. Whose responsibility is it to relay the incidental finding so that there is adequate follow-up? Traditionally this has fallen on the shoulders of the emergency department physician, but this is not necessarily correct. In reality, follow-up for patients with incidental findings is a major quandary for both the radiology and emergency departments.

Most inpatient admissions require follow-up upon discharge and outpatient radiology services are commonly referred by the patient's treating physician and are reviewed by that physician. In contrast, a patient typically presents to the emergency department for a major, one-time issue. The ideal situation would be for the radiologist to provide results and incidental finding to the emergency department physician, who would then provide it to the patient before they are discharged. Barriers arise when;

- The patient is medicated, sedated or in too much pain to comprehend the information.
- The patient has a primary care physician that is not listed in the hospital system and who may not receive the report.
- The patient does not understand the significance of the findings, or
- The patient does not have insurance and does not know how to follow-up with care.

The latter is particularly true when the patient uses the emergency department as a primary care location.

A study conducted in 2013 found that 4.5% of emergency department visits resulted in additional radiology services being requested, but 51% of the discharge reports for those visits did not have the findings. A similar 2011 study looked at CT scans performed in the emergency department and discovered that 33% of the CT scans performed contained incidental findings, but only 9.8 percent of those findings were present on the discharge paperwork.

If the findings are not available before the patient leaves the hospital, the patient must be contacted. Patient contact outside of the hospital has its own problems as patients provide incorrect phone information 5% of the time. Even when the correct phone number is provided, patients may not return calls or the patient is just unavailable. Mailing letters to the patient can have the same outcome. The question that many hospitals face is this: How often do you try to make contact? There is no simple answer, but many physicians try to contact the patient once or twice and, if there is no response, send a certified letter to the patient. Unfortunately, even this is not a fool proof method and patients may still get lost in follow-up.[1]

Most radiology groups and hospitals adhere to the American College of Radiology (ACR) follow-up requirements, which requires that a phone call or a letter be sent to the patient. Many believe this is not enough as patients don't always understand the importance of the findings or the necessity for follow-up. More attempts must be made to not only reach the patients, but to ensure they understand the results of their tests.

The issue lies with who is responsible in reporting the findings to the patient. In reality, notifying the patient needs to be a collaborative effort between the radiologist and the emergency room physician. Many in the field of radiology believe that if a report is better regulated, it will provide more impact and provide better options for action, resulting in an improved chance for follow-up care. However, this implies that the end user of the report is infallible. Experience shows that even if a patient receives the follow-up recommendation, they often don't adhere to the recommendation.

The problem is that emergency department patients are the least likely to follow-up especially when they use the emergency department as their source of primary care. It is this group that is most apt to fall through the cracks. The question has been asked; how do those patients receive the necessary information and how do we get them to understand the necessity for follow-up treatment and testing? Several hospitals across the country are striving for a viable solution.

Hershey Medical Center, for example, has created a program called Failsafe, which places the patient in the communication chain between the radiologist and the emergency department physician. When the radiologist discovers an incidental finding that does not require immediate action, they send a letter to the patient about the finding. This is sent per HIPPA guidelines; therefore, it is vague and only says that something was found incidental to the study performed during the emergency department visit. This letter then urges the patient to follow-up with their primary care physician or if the patient does not have one, the Hershey Medical Canter Family Medicine Department. Although the family medicine department has waiting lists, they have agreed that patients who receive letters will been seen within two weeks.

The radiology department sends six to eight letters per week, which are reviewed by members of a committee to assure the program guidelines are followed. Since the introduction of the program in 2012, only two patients have taken advantage of the offer by the family health department. This means that the patient is either following up with their primary care physician or is not following-up at all.

There was a concern that patients would be worried by the letters sent under the Failsafe program, so a series of phone calls were made asking the patients who received letters whether they were frightened by the letters. The response was a resounding no. In 2013, 80% of the patients that received letters and follow-up calls made follow-up calls. A year later in 2014, however, patients had very little interest in the letters or follow-up. Hershey Medical Center staff is now making their follow-up calls within two weeks of sending the letter. They are in the process of staffing nurses to make these calls so that patient questions can be answered as well as to drive home the importance of following-up on the findings. [2]

Likewise, Massachusetts General Hospital is working on tracking incidental findings in radiology reports that result from emergency department visits so that this information can be relayed to the patient as quickly as possible. They are also training nurses to read these reports in order to have them follow-up with patients and their primary care physicians.[3]

There have been several law suits instigated due to incidental findings that were not relayed to the patient and, in some cases, a potentially life threatening disease was discovered years later. The patients felt that they should have been made aware of the incidental findings. How does an emergency department safeguard against legal repercussions?

The following protocols for creating a policy do not safeguard a hospital or physician from being named in a malpractice suit, but they do provide some defense in the event of a lawsuit. The emergency department must have a written policy for following-up with the patient; and the policy needs to be followed consistently.

- First, the radiologist must report findings to the emergency department physician, who then decides what to present to the patient. For example, if the emergency department has a policy that an incidental finding under a certain size or of a certain type is not going to be reported, this provides a defense when the emergency physician is asked, why wasn't this reported to the patient? The doctor can provide that this was due to department policy (presumably based on a medical standard) rather than, I have no reason.
- Second, the patient should be provided with the radiologist's interpretation showing the incidental findings. This should be documented in the patient's chart and include any attempt to advise the patient to follow-up with their primary care physician, along with the timeframe for seeking follow-up care.
- Finally, emergency department physicians should document any follow-up with the admitting physician about the incidental finding. The assumption that the admitting physician is going to explain the findings to the patient cannot occur. Instead, the emergency physician needs to be proactive. [4]

Reporting incidental findings to the patient and getting proper follow-up treatment within a timely manner remains a challenge for radiology and emergency departments alike. However, this is not impossible when the two departments work as a team. Hershey Medical Center and Massachusetts General Hospital are examples of hospitals working on the issue in similar ways to implement best efforts and practices to inform patients of any medical findings and to explain the importance of following-up on those findings. As these two hospitals show, protocols can be established to not only make getting the patient this information a possibility, but also a reality.

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[1] Abram Kaplan, Deborah, " The Elusive Incidental Finding," *Diagnostic Imaging*, April 9, 2015.
[2] Abrams Kaplan, Deborah, "After the Incidental Finding," *Diagnostic Imaging*, April 9, 2015.
[3] Richards, Veronica, "Why Hospitals must do More to Address Incidental Findings," *Richards & Richards, LLP Attorneys at Law*, November 20, 2014.
[4] "EPs Seeing Many More Incidental Findings: Take Steps to Reduce Liability," *AHC Media ED Legal Letter*, April 5, 2015.

ACR Study Finds ER Imaging for Low-Back Pain Appropriate

Low back pain without trauma has been and still is a common presenting complaint in emergency departments and, in many cases, diagnostic imaging tests have been done to find the cause of the pain. In 2006, more than 2.6 million visits to the ED were made with back pain as the presenting complaint. Of those visits, more than 30 percent underwent an X-ray, and nearly 10 percent underwent CT or MRI, an increase from 3.2 percent in 2002.[1]

As we all know, in recent years, particularly since the passage of the Affordable Care Act, there has been increased scrutiny of diagnostic imaging tests to identify unnecessary imaging in order to lower costs and reduce ionizing radiation exposure. Imaging for lower back pain was one of those tests under scrutiny, and in October 2014, the American College of Emergency Physicians (ACEP) included the use of lumbar spine imaging in the emergency department on its list for the ABIM (American Board of Internal Medicine) Foundation's Choosing Wisely® campaign.

The ACEP along with the American College of Radiology (ACR) have determined that diagnostic imaging does not accurately identify the cause of most lower back pain, does not improve the time to recovery and, in most cases, is not associated with improvement in back-pain clinical outcomes.

According to a study recently published in the Journal of the American College of Radiology (JACR), emergency room physicians may be adhering to those guidelines. The study included patients with a chief complaint of "low back pain" from January 2013 through April 2013 to determine the incidence of appropriate imaging among emergency department (ED) patients with low back pain. Of 624 patients, 100 were randomly selected and analyzed for their demographics, presentation, imaging, treatment, and outcomes. The study indication for imaging was compared with the ACR Appropriateness Criteria for low-back pain imaging.

The results of the study supported the reasoning that imaging for low back pain is unnecessary in most cases. A total of 28 (28%) patients underwent imaging in the ED; 24 (24%) had outpatient imaging; 54 (54%) had neither ED nor outpatient imaging. In all, 96% (27 of 28) of patients imaged in the ED, and 96% (23 of 24) imaged as outpatients, were appropriately imaged. Of patients who did not undergo imaging, 96% (52 of 54) were appropriately not imaged

Emergency room physicians have two roles in evaluating back pain: to treat patients' symptoms and to diagnose potentially life-or limb-threatening causes. For treating patients' symptoms, guidelines from the American College of Physicians and the American Pain Society emphasize a focused history and physical examination, reassurance, patient education, initial pain management medications if necessary (acetaminophen or nonsteroidal anti-inflammatory drugs), and consideration of physical therapies without routine imaging in patients with nonspecific LBP.[2]

Imaging is considered for those without improvement after 6 weeks and for those where the patient has severe progressive neurologic deficits or is suspected of having a serious underlying condition, such as vertebral infection or cancer with bony metastasis, bowel or bladder incontinence, IV drug abuse or unexplained fever and advanced age (typically →70 years).[3]

After a thorough history of the patient, delineating the onset of the pain, precipitating factors, prior episodes of pain, and information regarding prior treatments, imaging and surgery, the emergency physician should be able to risk stratify the patient and determine if imaging is necessary.[4]

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[1] Lin, MD, MPH, Michelle and Schur, MD, MHS, Jeremiah D., "A High Value Diagnostic Approach to Low-Back Pain," ACEP Now, March 7, 2014.
[2] American College of Radiology, ACR Appropriateness Criteria
[3] Lin, MD, MPH, Michelle and Schur, MD, MHS, Jeremiah D., "A High Value Diagnostic Approach to Low-Back Pain," ACEP Now, March 7, 2014.
[4] Emergency Medicine Practice Abstract, An Evidence-Based Approach To The Evaluation And Treatment Of Low Back Pain In The Emergency Department, July 2013, Volume 15, No.7.

Supreme Court Denies Challenge to ACA in King v. Burwell

Insurance premium subsidies provided by the Affordable Care Act ("Obamacare") continue to be available to Americans in all states. The U.S. Supreme Court 6 to 3 ruling on June 25 in King v. Burwell means the premium subsidies remain accessible to healthcare exchange enrollees in all states.

Prior to the ruling, there was great concern about the impact had the ruling gone the other way. 6.4 million people were at risk of losing their subsidies, and many were concerned about the possibility of chaos in the private insurance market. Had the court ruled against the subsidies, many feared a significant impact on individual health insurance consumers, health insurers, health care providers and employers. Depending on transition assumptions, the timing could have been problematic. Key state and federal deadlines for establishing exchanges in 2016 have already passed, and others are quickly approaching. Without a clear pathway for states to quickly set up an exchange, states had few options for quickly establishing an exchange. Plus health insurers are already well down the road in deciding which products to offer and the accompanying fees for 2016.[1]

The ruling sided with the Obama administration and against the plaintiffs who argued that the literal ACA language limited subsidies to only those exchanges established by a state. ACA supporters were concerned that, had this ruling gone the other way, the most popular ACA provision, namely the prohibition against health insurers taking pre-existing conditions into account when setting premiums or scheduling benefits, would have been in jeopardy. ACA supporters insist the two features go hand in hand because the law forces health insurers to accept any applicants without taking pre-existing conditions into consideration and charge everyone the same age (except tobacco users) the same premium.[2]

Leading up to the Court's decision, King vs. Burwell caught the attention of a number of institutions who analyzed the possible impact of the imminent ruling. In a recent report released by the American Academy of Actuaries, it warned that an adverse decisions could lead to pressure on the individual mandate, with the risk of causing a great deal of damage. The report also cautioned that removing the individual mandate altogether could impact the viability of the entire market, resulting in significantly increased premiums for those remaining.

In anticipation of the Court's ruling, some states had already permitted exchange plans to file two sets of rates for 2016, while others had spent months strategizing how to respond to the disruption if the Court had opted to rule against the ACA. [3] Many worried a decision in the opposite direction would lead to a dramatic spike in the nation's uninsured and the disintegration of the healthcare law itself. Avalere's analysis estimated approximately 2.3 million exchange enrollees (37 percent of those enrolled) were uninsured before enrolling in exchange coverage and that these consumers would be unlikely to continue purchasing coverage without access to subsidies.

The three opposing Justices along with others not in favor of the ruling criticized the majority by stating that the law is ambiguous, pointing to a specific part of the law that says subsidies are only available to those who enroll through an "exchange established by the state." The Internal Revenue Service has interpreted this to allow subsidies in all states, but opposing parties in the case disagreed. They feel the court should have employed the Chevron doctrine,

a common policy that says federal agencies must follow the letter of the law where the law is clear and if a law is ambiguous, courts must defer to a government agency's reasonable interpretation of it. The Justices explained that the utilization of the Chevron doctrine would not be appropriate for this case, saying that it would be extremely unlikely that Congress would have delegated the interpretation of the law to the IRS. The federal government argued that the law's purpose is clear, and has been indicated to be so in other parts of the law maintaining that Americans in every state should be allowed the right to be eligible for subsidies. [4]

Leavitt Partners' state-specific fact sheets: 'King v. Burwell State Impact Fact Sheets' have further information about how a ruling in favor of the plaintiffs would have impacted each individual state.

[1] McDermott Will & Emery, "*King v. Burwell*: When Would a Supreme Court Ruling Restricting Affordable Care Act Premium Subsidies Go into Effect?", June 19, 2015
[2] Graham, John, "King v. Burwell: How Important Is Obamacare's Individual Mandate?", Forbes: Healthcare, Fiscal, and Tax, June 6, 2015
[3] June 8, 2015 – Radiology Business Management Association – RBMA Washington Insider – King v. Burwell Update http://www.rbma.org/RBMA_Washington_Insider_2015_06_08/#1
[4] Schencker, Lisa, "BREAKING: Supreme Court upholds subsidies in King v. Burwell", Modern Healthcare, June 25, 2015

The Cadillac Tax: Big Impacts Expected

The "Cadillac Tax" is an excise tax included in the Affordable Care Act (ACA) to slow healthcare spending growth and to help offset the ACA costs. It is scheduled to be in place for 2018 and will tax employers who offer their employees "Cadillac" health insurance plans ($10,200 for an individual and $27,500 for families).

Businesses, especially those with traditional or generous health plans, now have much to consider. The Spring Healthcare Trend Survey from Wells Fargo Insurance analyzed more than 65 insurers nationwide and found that 38 percent of large employers will likely hit the tax threshold in 2018 if they do not make changes to their plan.

Small and mid-size employers with traditional health plans may be less aware of the upcoming tax. This includes many healthcare companies, including physician groups and hospitals. As a result, the "Cadillac Tax" may come as a surprise to some, especially considering the magnitude of the 40 percent tax–which applies to every dollar above the threshold.

In preparation, some employers are opting for high-deductible coverage with an optional health savings account. The most recent survey from the International Foundation of Employee Benefit Plans (IFEBP) shows that due to the Affordable Care Act:

- Nearly 10 percent of the surveyed organizations are putting a full-replacement high-deductible health plan in place.
- 11 percent of those surveyed are considering high-deductible health plans with no savings accounts, while 13 percent plan to use high-deductible health plans with a health reimbursement arrangement (versus an HSA).
- A small percentage (6%) have implemented or expanded the use of low-cost "skinny plans", while 3 percent more plan to do so over the coming year.

Employers providing health insurance to their employees will still be able to write off the cost of offering coverage from their taxes, but under the Cadillac Tax, it is also possible that the open-ended tax breaks employers receive for providing coverage will ultimately inflate healthcare costs. [1]

As more employers opt for high-deductible health plans, there is growing concern about financial stress from patients' inability to afford the deductible costs. More than 1 in 5 organizations have been forced to either increase copayments or coinsurances for primary care, increase participants' share of prescription drug costs, or increase the employees' share of dependent coverage costs. Of the businesses surveyed, increasing the employee portion of dependent coverage cost (13 percent) and increasing copayments or coinsurances for primary care (11 percent) were found to be the most common cost-management plans over the next 12 months. Since many companies will want to avoid the steep excise tax, the financial pressures on patients seem likely to increase. [2]

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[1] Zweig, Dori, "'Cadillac tax' could be latest threat to Affordable Care Act", *Fierce Health Payer*, April 6, 2015
[2] Mrkvicka, Neil et al, "'2015 Employer-Sponsored Health Care: ACA's Impact' Survey Results", *International Foundation of Employee Benefit Plans*, 2015

Medicare Turns 50!

(Logo designed by the HBMA)

On July 30, 2015, Medicare will be 50 years old. And while many in the health care community like to complain about aspects of the program, it has certainly provided millions of seniors and disabled citizens with much needed healthcare.

Although it seems like Medicare has been around forever, its legislation was only introduced in 1965. At that time, only about half of Americans who were 65 years of age or older had any health insurance, and many of their policies did not offer meaningful health care coverage. To add to the problem, seniors were the sickest population making them unattractive to private insurers in the individual health insurance market. They faced medical bills roughly triple those for everyone else.[1]

However, during the 50's and early 60's, seniors were a strong political constituency and demographic trends showed that this population would grow tremendously over time. Their large voting block influenced proposed legislation to provide retired Americans with health insurance that began with President Truman and continued through the Kennedy years. Finally, in 1965, President Lyndon Johnson persuaded Congress to pass a final Medicare bill including hospital coverage (Part A), physician coverage (Part B) and Medicaid, an additional program designed to help the poor with health coverage.

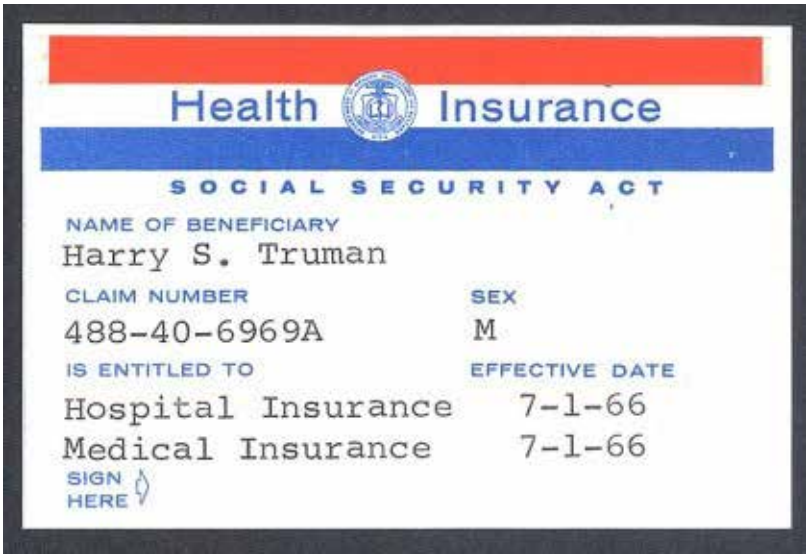
Medicare coverage encouraged the elderly to use medical services. Between 1963 and 1970, the rate of hospital admissions per 100 elderly Americans rose from 18 to 21 annually and the proportion of elderly persons who had contact with a physician each year increased from 68% to 76%.

Over the years, as medical costs grew, so did Medicare expenditures. Spending per Medicare beneficiary increased from $385 in 1970 to $12,210 in 2013. Aggregate spending has grown from 0.7% of the gross domestic product (GDP) in 1970 to 3.5% today.[2]

The following timeline highlights the important legislative steps in Medicare's journey from 1966 through today, all with the objective to improve care and coverage at an affordable cost to Seniors while containing the cost.

The Medicare Journey

The following Medicare Journey timeline draws from the Kaiser and MedPage articles shown in the Resource section below.



The First Medicare Card

July 30, 1965 – *Medicare Signed in to law* – President Lyndon Johnson signs H.R. 6675, establishing Medicare for the elderly and Medicaid for people with low income and limited resources.

July 1, 1966 – *Benefits begins* – More than 19 million Americans aged 65 or older enroll in the Medicare program. At the time, the cost for Medicare Part A deductible was $40 per year and Medicare Part B premium was $3 per month.

October 30, 1972 – *Disability Coverage* – President Richard Nixon signs the Social Security Amendments of 1972, the first major change to Medicare since its inception. Under the legislation, coverage is expanded to people younger than 65 with long-term disabilities and individuals with end-stage renal-disease.

1977 – *HCFA is born* – The Health Care Financing Administration (HCFA) is created to integrate and administer both Medicare and Medicaid and begins to oversee costs.

July 18, 1984 – *Deficit Reduction Act of 1984* – DEFRA froze physician fees, established the "participating physician or supplier" agreement, and established fee schedules for laboratory services

April 7, 1986 – *Review of Reimbursement Policies* –The Physician Payment Review Commission (PPRC) was created as part of the Omnibus Budget Reconciliation Act of 1986. The PPRC's mission was to slow down costs and recommend future reimbursement policies for physicians.

December 19, 1989 – *Omnibus Budget Reconciliation Act of 1989* – Congress replaces reimbursement of reasonable and customary charges with a physician fee schedule derived

from a resource-based relative-value scale (RBRVS). Limits are placed on physician balance billing and physicians are prohibited from referring Medicare patients to clinical laboratories in which they have a financial interest.

1997 – ***The Sustainable Growth Rate and Medicare Advantage*** –The Balanced Budget Act of 1997 created a host of changes to the program. Most notably, it implemented the sustainable growth rate (SGR) formula, which was set to begin in 2003. The SGR was to be a mechanism to reduce fees if Medicare spending on physicians' services exceeded an aggregate target. The Act also created the State Children's Health Insurance Program (SCHIP) and Medicare Part C, now called Medicare Advantage. That program formally gave beneficiaries the option of an HMO-style Medicare plan instead of the fee-for-service program.

1998 – ***Medicare.gov*** – The federal government designed its first website to provide updated information on the Medicare program.

2000 – ***SCHIP expanded*** – The Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 increased payments to providers and reduced some copayments for beneficiaries.

2001 – ***HCFA becomes CMS*** – The Health Care Financing Administration is renamed to The Center for Medicare and Medicaid Services (CMS).

December 8, 2003 – ***Modernization Act*** – The "Medicare Prescription Drug, Improvement, and Modernization Act" is signed in to law by President George W. Bush. Among the many changes, the MMA made a prescription-drug benefit available, on a voluntary basis and only from private plans, with a premium paid directly to the plan which would go in to effect in 2006.

January 1, 2006 – ***Part D begins*** – Medicare Part D, created as part of the 2003 MMA, goes into effect and Medicare beneficiaries begin receiving subsidized prescription drug coverage. In 2013, a total of 39.1 million Medicare beneficiaries were enrolled in a Medicare prescription-drug plan.

March 23, 2010 – ***the Patient Protection and Affordable Care Act (ACA)*** – President Obama signs the ACA which mandates that Medicare beneficiaries receive certain free preventive care services and health screenings, a free annual wellness exam and also reduces the out-of-pocket expenses of Part D enrollees. It also created the Center for Medicare and Medicaid Innovation, which received $10 billion to develop, assess, and disseminate new payment approaches and other strategies that are designed to improve quality and lower spending for health care services. These innovations include the introduction of their Accountable Care Organizations (ACOs), the Bundled Payments for Care Improvement Initiative, the Comprehensive ESRD Care Initiative, the Community-based Care Transitions Program, and the Comprehensive Primary Care Initiative.

The ACA also implemented a quality-rating system for Medicare Advantage plans to provide higher payments to plans earning higher ratings.

August 2, 2011 – ***Budget Control Act of 2011*** – The law includes provisions to reduce net federal spending by $2.1 trillion over ten years and raise the debt ceiling by up to $2.4 trillion. The law also specifies that if a proposal from the Joint Select Committee on Deficit Reduction is not enacted, a sequester of $1.2 trillion over 10 years would go into effect January 2, 2013, resulting in a

sequestration of up to two percent of Medicare payments to providers and plans.

April 1, 2013 – ***Medicare Sequestration of 2%*** goes into effect

April 1, 2014 – ***Protecting Access to Medicare Act of 2014*** prevents a 24 percent cut to payments for physician services due to SGR formula. Instead, it institutes a 12-month "doc fix" in traditional Medicare, which freezes payment rates through March 31, 2015. This is the 17th law instituting a doc fix since 2003. The Act also extends several otherwise expiring provisions, including the Medicare therapy cap exceptions process and the Qualifying Individual Program.

2015 ***Medicare Costs*** (See the above Qualifying Individual Program)

- ***Part A*** – Beneficiaries usually do not pay a monthly premium for Medicare Part A (Hospital Insurance) coverage if they or their spouse paid Medicare taxes while working. This is sometimes called "premium-free Part A." If a beneficiary must buy Part A, they can pay up to $407 each month.
- ***Part B*** premium is $104.90 per month with a $147 year deductible. For those beneficiaries who make over $85,000 a year, the premium is higher.

April 15, 2015 – ***SGR is repealed*** and replaced with a 0.5% update to the current conversion factor from July 1, 2015 thru December 31, 2015. Providers will then receive an annual 0.5% update through 2019. The 2019 rate will be maintained through 2025 while giving providers the opportunity to receive additional payment adjustments through the new Merit-Based Incentive Payment System (MIPS). In 2026 and beyond, providers participating in APMS (Alternative Payment Models) that meet certain criteria will receive annual updates of .75%, while all other professional will receive annual updates of .25%.

Resources

Kaiser Medicare Timeline

NE Journal of Medicine article part 1

MedPage – Medicare at 50

[1] Blumenthal, M.D., M.P.P., David, et al, "Medicare at 50 – Origins and Evolution," N*ew England Journal of Medicine*, January 29, 2015.
[2] Ibid

Customer Survey Insights

As most readers know, AdvantEdge conducts an annual survey of its clients in the first quarter of each year. Results help AdvantEdge Client Managers, operations and executives focus the company's energy on those items that have the highest value to clients.

In this article, we share insights from this year's survey. One of the first survey questions asks about the importance of different aspects of our service: e.g. meeting frequency, reports, problem resolution, etc. Like previous years but more so, this year's respondents (representing almost one third of AdvantEdge clients) say the top priority isn't one thing, but several. Namely, a combination of payments (meaning cash collected) plus accessibility and responsiveness. In other words: performance and service.

When asked how we are doing on these important factors, the vast majority of clients say "good" or "excellent." Of course, there is always room for improvement and open-ended questions invite suggestions and comments. Along those lines, we heard about ICD-10 (a lot), PQRS, meaningful use, specific ideas for new reports, etc. But mostly we heard nice things about Client Managers. Things like "Our client manager is outstanding", "Our client manager is attentive, thorough, and prompt", and "The best aspect of working with AdvantEdge is the personal contact; having the same people managing and working on our account; having people who are experienced and knowledgeable."

Consistent with those comments, when asked to rate AdvantEdge performance, customers give high marks for responsiveness, including reports and access to information. This matches with the AdvantEdge commitment of full transparency in billing.

While the positive results are gratifying, the AdvantEdge team isn't taking them for granted. We all know that positive ratings only happen when our work is done effectively, day in and day out. Customers make that clear in the survey and AdvantEdge workflows, training and leadership focus on top quality results with responsive service every day.

HIPAA Security Data Breaches – The News is NOT Getting Better!

On May 15th, news reports described a significant data breach by a Business Associate. The investigation focused on one rogue employee from the North Carolina based billing company Medical Management LLC (MML). The result, so far, is forty of the billing company's clients having to notify patients. The clients identified so far have facilities in NY, NJ, PA and IL.

The reports describe a call center employee (since terminated by MML and also arrested) who copied personal information items from the billing system over the past two years and then illegally disclosed that information to a third party. Federal Authorities are involved in the investigation and they notified MML of the activity. The personal information that was accessed and potentially compromised included names, dates of birth and social security numbers. There is no evidence, at this time, that information about medical history or treatment was disclosed.

HIPAA requires covered entities and business associates to "secure all electronic protected health information against accidental or intentional causes of: unauthorized access, theft, loss or destruction, from either internal or external sources." HIPAA security regulations govern electronic records, while HIPAA's privacy rules apply to paper records.

"Theft", "Unauthorized Access" and "Loss" dominate as reasons for breaches, and the latest breach statistics are staggering; from March 2009 through April 2015, **more than 133 million patient records have been affected by 1,199 HITECH Act breaches**, according to a report recently released by the HHS Office for Civil Rights (OCR) https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf

And, according to a study by Kaiser Permanente, recently published in the *Journal of the American Medical Association*, of health record breaches reported between 2010 and 2013, the percentage of breaches attributed to hacking more than doubled during the three-year period, accounting for 12% of incidents in 2010 and 27% in 2013. However, such incidents comprised less than one-third of all large-scale reported breaches. Researchers noted that more than 50% of the breaches resulted from loss or theft of laptops, paper records, and thumb drives[1]

Please note that these statistics are HIPAA related breaches only, they do not include the hundreds of millions affected by online financial breaches at companies such as Target, TJ Maxx, Home Depot, etc.

In addition, many healthcare breaches still go unreported, and many breach offenders don't make the OCR's "wall of shame." Moreover, breaches involving the health records of fewer than 500 individuals do not have to be publicly reported, which also skews the reported numbers.

Why is Healthcare Data Theft Growing?

Security experts say health data is showing up in the black market more and more. Records that contain a social security number or mother's maiden name are used for identity theft. Healthcare companies saw a 72% increase in cyber-attacks from 2013 to 2014, according to

the security firm Symantec. Researchers have also noted that the number of electronic data breaches likely will continue to rise as the use of EHRs quickly expands, along with increased adoption of Cloud-based analytics services, gene sequencing, personal health records, and other health-related technology.

Credit card numbers aren't worth very much to hackers anymore since credit card companies can shut down cards quickly; fifty cents to a dollar may be what a hacker can fetch for one on the black market. Health-related records are currently estimated to be ten to twenty times more valuable because the information can be used, for example, to set up fraudulent Medicare/Medicaid billing, and bill over and over.

Risk Analysis Inadequacies

Failure to perform and act upon a comprehensive risk analysis is often where companies lapse. Based on the complaints that OCR has received, risk analysis failures top the list for the biggest security issues. By understanding workflow, policies, and procedures, you get a more complete picture of what is actually happening in your environment, and from there you can implement a plan that significantly lowers your risk of breach.

Final Thoughts

Employees will make mistakes, and some may even steal. Hackers will never go away, and cyber criminals do not only target large companies. Here is a short list from Managed Solutions with tips to help you prevent a healthcare data breach.

1. Conduct a Risk Assessment

Stage One of the CMS EHR Meaningful Use incentive program requires that all providers conduct a risk assessment of their IT systems. This is in accordance with the HIPAA Privacy and Security Rules that govern the transmission of all electronic patient information. The risk assessment forces providers to review security policies, identify threats and uncover vulnerabilities within the system.

2. Provide Continued HIPAA Education to Employees

Educate and re-educate employees on current HIPAA rules and regulations. Furthermore, review and share state regulations involving privacy of patient information. If employees are in the know and reminded of the implications of data breaches, risk of violation can be drastically reduced.

3. Monitor Devices and Records

Remind employees to be watchful of electronic devices and/or paper records left unattended. More often than not, data breaches occur due to theft of these items from a home, office or vehicle. While it is "IT's" job to safeguard patient information, employees should be reminded to do their part in keeping data safe as well.

4. Encrypt Data and Hardware

Encryption technology is key when avoiding data breaches. While HIPAA doesn't require data to be encrypted, it also does not consider loss of encrypted data a breach. Therefore, be sure to encrypt patient information both at rest and in motion to avoid potential penalties. Furthermore, protect hardware such as servers, network end points, mobile and medical devices as these items are also vulnerable.

5. Subnet Wireless Networks

Ensure that networks made available for public use do not expose private patient information. One way of achieving this is to create sub-networks dedicated to guest activity and to separate more secure networks for medical devices and applications that transmit and carry sensitive patient information.

6. Manage Identity and Access Stringently

With so many members of the healthcare system frequently accessing patient information – for a multitude of different reasons – it is important to carefully manage the identity of users. For instance, make sure users are only granted access to information pertinent to their position and that log on/off procedures are easy and enforced on shared machines. Automation helps create a "paper trail" and ensures efficiency and safety for all involved.

7. Develop a Strict BYOD Policy

BYOD or Bring Your Own Device policies should be airtight and follow the same strict security guidelines outlined above.

8. Examine Service-Level Agreements Carefully

If you are considering moving patient information and data to the cloud, make sure you understand the Service-Level Agreement (SLA) with your potential Cloud Service Provider (CSP). Specifically, ensure that you, not the CSP own the data and that it can be accessed reliably, securely and, more importantly, timely (in the event of a crash). Also, verify that the SLA complies with HIPAA and state privacy laws.

9. Hold Business Associates Accountable for IT Security Policies

It is imperative to update business associate agreements to reflect evolving federal and state privacy regulations. Healthcare organizations often have hundreds or even thousands of vendors with access to patient data. In the event of a breach, the healthcare provider is ultimately responsible. Therefore, hold BAs accountable for providing security and risk assessments and develop processes for reporting breaches.

10. Establish Good Legal Counsel

In the event of a data breach, your organization will be investigated and most likely fined by the Office for Civil Rights. Lawsuits from patients will also ensue, so be sure to be prepared from a legal standpoint. Compliance is key, so don't be advised to withhold known information about the breach.

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[1] Doyle, Katherine, "Health Data Breaches on the Rise," *Reuters*, April 14, 2015.

AdvantEdge ICD-10 Readiness

With October 1 now only 4 months away, and counting, ICD-10 is looking very real!

AdvantEdge preparation efforts continue so that clients can be assured of a smooth transition. This includes systems, staff training, and much more. One key element directly impacts clients: physician training and preparation. For clients where AdvantEdge does diagnosis coding, provider documentation will need to become more specific. Clients who do their own diagnosis coding need to become familiar with the ICD-10 codes for their specialty.

System Readiness

Since 2011, the AdvantEdge development team has been managing a major project to change applications to process ICD-10 codes—in parallel with ICD-9 codes. We have been ready to initiate testing of ICD-10 codes with payers since 2013. In 2014, AdvantEdge was selected to partner with Emdeon to test ICD-10 processes since our systems were ready to test earlier than most others. Other tests were run in 2014 with payers prepared to do so. In 2015, end-to-end testing is underway with a number of Medicare MACs, commercial payers and clearinghouses.

Coding Readiness

The AdvantEdge coding team has been preparing for ICD-10 for the past two plus years, using the guidelines of the AAPC. Among other items, these guidelines strongly recommend expanded coder training in physiology and anatomy. AdvantEdge coders have completed the required anatomy and physiology education sessions through AHIMA that will be instrumental in the correct coding for ICD-1. In addition, our coders are gaining experience through dual coding of selected cases.

Two AdvantEdge coders are certified AHIMA ICD-10 trainers. They have established a comprehensive ICD-10 curriculum which all AdvantEdge coders are completing. Every AdvantEdge coder is currently certified for ICD-9 and is required to complete training and be recertified for ICD-10.

Client Readiness

The largest impact of ICD-10 may be on AdvantEdge clients and their physicians. This is because of the additional documentation required in order for AdvantEdge coders to assign the correct ICD-10 code. To assist that process, this newsletter has been publishing ICD-9 / ICD-10 comparisons for the past 3 years, including in this issue. Recently, those comparisons were compiled for Radiology, Pathology and Anesthesia. Those cross walk documents have gotten very positive feedback from clients and client managers. In addition, several AdvantEdge whitepapers are available that provide additional details to help with ICD-10 planning. As an example, most hospital-based physicians will need additional information from their referring / ordering physicians in order to have enough detail for an ICD-10 report.

Summary

AdvantEdge Healthcare Solutions is confident that the company and its clients will be ready for the ICD-10 transition on October 1, 2015.

If you have any questions, please contact your AdvantEdge Client Manager.

ICD-9 to ICD-10: Open Wound of Elbow, Forearm and Wrist

Diagnosis: Open Wound of Elbow, Forearm and Wrist

ICD-9 Code(s): 881.00 – 881.22

Listed Under: Injury And Poisoning 800-999 → Open Wound Of Upper Limb 880-887 →

ICD-10 Code(s) S51.001 – S51.009, S51.021 – S51.029, S51-801-S51.809, S51.821-S51.829, S51.801 – S51.809, S56.921-S56.929

Listed Under: Injury, poisoning and certain other consequences of external causes S00-T88 → Injuries to the elbow and forearm S50-S59 →

ICD-10 Code(s)S61.501 – S61.509, S61.521-S61.529, S66.921-S61.929

Listed Under: Injury, poisoning and certain other consequences of external causes S00-T88 → Injuries to the wrist, hand and fingers S60-S69 →

For ICD-10, codes are available for each side of the body as well as for the description of the encounter which is identified by the letter at the end of the code.

- A – Initial encounter
- D – Subsequent encounter
- S – Sequela

Diagnoses in shaded areas are titles only and are not billable

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description
Open Wound of Elbow, Forearm and Wrist	**881**	**S51, S56, S61, S66**	**Open Wound of Elbow, Forearm and Wrist**
Open wound of elbow, w/out mention of complication	881.00	S51.801 A, D, S	Unspecified open wound of right forearm
		S51.802 A, D, S	Unspecified open wound of left forearm
		S51.809 A, D, S	Unspecified open wound of unspecified forearm
Open wound of elbow, w/out mention of complication	881.01	S51.001 A, D, S	Unspecified open wound of right elbow
		S51.002 A, D, S	Unspecified open wound of left elbow
		A51.009 A, D, S	Unspecified open wound of unspecified elbow
Open wound of wrist, w/out mention of complication	881.02	S61.501 A, D, S	Unspecified open wound of right wrist
		S61.502 A, D, S	Unspecified open wound of left wrist
		S61.509 A, D, S	Unspecified open wound of unspecified wrist

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description
Open wound of forearm, complicated	881.10	S51.821 A, D, S	Laceration with foreign body of right forearm
		S51.822 A, D, S	Laceration with foreign body of left forearm
		S51.829 A, D, S	Laceration with foreign body of unspecified forearm
Open wound of elbow, complicated	881.11	S51.021 A, D, S	Laceration with foreign body of right elbow
		S51.022 A, D, S	Laceration with foreign body of left elbow
		S51.029 A, D, S	Laceration with foreign body of unspecified elbow
Open wound of wrist, complicated	881.12	S61.521 A, D, S	Laceration with foreign body of right wrist
		S61.522 A, D, S	Laceration with foreign body of left wrist
		S61.529 A, D, S	Laceration with foreign body of unspecified wrist
Open wound of forearm, with tendon involvement	881.20	S56.921 A, D, S	Laceration of unspecified muscles, fascia and tendons at forearm level, right arm
		S56.922 A, D, S	Laceration of unspecified muscles, fascia and tendons at forearm level, left arm
		S56.929 A, D, S	Laceration of unspecified muscles, fascia and tendons at forearm level, unspecified arm
		S51.809 A, D, S	Unspecified open wound of unspecified forearm
Open wound of elbow, with tendon involvement	881.21	S56.921 A, D, S	Laceration of unspecified muscles, fascia and tendons at forearm level, right arm
		S56.922 A, D, S	Laceration of unspecified muscles, fascia and tendons at forearm level, left arm
		S56.929 A, D, S	Laceration of unspecified muscles, fascia and tendons at forearm level, unspecified arm
		A51.009 A, D, S	Unspecified open wound of unspecified elbow
Open wound of wrist, with tendon involvement	881.22	S66.921 A, D, S	Laceration of unspecified muscle, fascia and tendon at wrist and hand level, right hand
		S66.922 A, D, S	Laceration of unspecified muscle, fascia and tendon at wrist and hand level, left hand
		S66.929 A, D, S	Laceration of unspecified muscle, fascia and tendon at wrist and hand level, unspecified hand
		S61.509 A, D, S	Unspecified open wound of unspecified wrist