Hundreds of State and National Physician Groups Urge Congress to Fix Medicare Now

More than 750 organizations joined the American Medical Association (AMA) today to call on Congress to pass legislation that would permanently eliminate Medicare’s flawed sustainable growth rate (SGR) formula and strengthen Medicare for America’s seniors. In a letter to House and Senate leadership, the groups strongly urged policymakers to pass the bipartisan, bicameral framework developed last year.

“We make significant progress in the previous Congress to find common ground for a Medicare fix that would establish a clear pathway for developing and implementing new health care delivery and payment modes that improve quality, coordinate care and reduce costs,” said AMA President Robert M. Wah, MD. “It would be a shame to once again let that solution, which took many months to develop, go to waste.”

The current SGR patch expires on March 31, after which all physicians could face a devastating 21 percent cut in Medicare payments. The looming cuts and repeated cycle of passing expensive legislative patches not only creates uncertainty and unpredictability, it also impedes physicians ability to provide the highest quality care for their patients as part of a sustainable and stable Medicare program. Physicians need the SGR to be permanently eliminated and for the reforms in the policy from last year to be passed to implement innovative health care delivery and payment modes, which are already proving successful in reducing costs and increasing access to high-quality care.

“We remain optimistic that our collective voices will make a difference and that Congress will finally act on eliminating the SGR,” said Dr. Wah. “It’s time to end this annual game of kicking the can down the road that is unfair to patients and physicians and wastes taxpayer dollars.”

Source: AMA, March 16, 2015

Health insurance and human resource requirements

As of Jan. 1, 2014, no employer or health plan (fully- and self-insured) can impose a waiting period that exceeds 90 days after an employee is otherwise eligible for health coverage. To ensure that eligibility conditions based solely on the passage of time are not used to evade the waiting period limit, the new rules are that such conditions cannot exceed 90 days.

The stopwatch for 90 days starts ticking after the employee is “otherwise eligible.” This means the employee has satisfied the plan’s substantive (non-time based) eligibility requirements like being in an eligible job class, holding full-time status, etc.

To clarify, “90 days means just that, 90 days. It does not mean first of the month following 90 days, and it does not mean three months. Likewise, there is no extension for holidays or weekends. If the 91st day is a holiday or weekend and the employer cannot provide coverage effective on that day, coverage MUST be effective sooner.

Employees caught in the transition (hired before the start of the 2014 plan year and not satisfied the plan’s waiting period) must be given credit for their prior waiting period time. Put more simply, no one who gains coverage after the start of the 2014 plan year can be required to wait more than 90 days after their hire date.

Source: Dept of Labor and Workman Benefits

Join the discussion: Send in your letters and articles

A blog created by Texas Medical Association (TMA) is designed so that patients and doctors can have a candid dialog about health care issues. Let your voice be heard. Send TMA your article, video, or photos today. Go to www.meandmydoctor.com.
TMA Asks Feds to Avert ICD-10 Calamity

Describing the Oct. 1 mandatory transition to ICD-10 as a “potential calamity,” Texas Medical Association President Austin King, MD, asked the Centers for Medicare & Medicaid Services (CMS) to consider some moves that would make the transition less risky for physicians and patients.

Because many physician practices simply aren’t ready for it, Dr. King said, the transition could spell disaster and would “disrupt hundreds of thousands of physician practices across the country and threaten the patients who depend on us for care.” A recent poll showed just 21 percent of physician practices surveyed say they’re on track to be ready Oct. 1.

CMS has completed three rounds of end-to-end ICD-10 testing and reported acceptance rates of 89 percent (March 2014), 76 percent (November 2014), and 81 percent (February 2015). And while the results show most rejected claims were not ICD-10 related errors but errors submitters made, Dr. King said in his March 11 letter, they still indicate serious problems.

“It is reasonable to assume that all of those participating in the testing believed they were prepared for the ICD-10 transition,” Dr. King said. “And at least some of those test claims that were accepted likely would have been rejected further down the line for errors unrelated to the acceptance process.”

Dr. King expressed particular concern for the readiness of small practices, such as the 63 percent of Texas physicians who are solo practitioners or who practice in groups of three or fewer. In his letter, he outlined three specific request for CMS consideration:

1. Permit a concurrent transition, allowing for the use of either ICD-9 or ICD-10 for a period of two years following the Oct. 1, 2015, implementation date;
2. Provide a safe haven period during this two-year transition during which physicians will not be penalized for the errors, mistakes, and/or malfunctions that are certain to occur during that transition period; and
3. Require all electronic health record, practice management, and billing companies to complete all software upgrades no less than three months in advance of the Oct. 1 transition date. Current rules only require that the upgrades be ready by that date. It is imperative that properly functioning software be installed in physician offices with sufficient time to allow proper testing and subsequent adjustments.

For more practice help on ICD-10 visit TMA’s ICD-10 Resource Center.

Source: TMA Action, March 16, 2015
**Quality Corner**

**Choosing Wisely®**

The national Choosing Wisely® campaign, a physician-led endeavor, was launched in April 2012, as an initiative of the American Board of Internal Medicine (ABIM). In the campaign, the top five tests or procedures commonly used in each specialty are identified and their necessity is questioned and discussed. The goal of the campaign is to start a conversation among physicians and patients about whether, when and why these tests are appropriate. In addition to helping patients choose treatments that are evidence based, not harmful, not duplicative, and truly necessary. Since the conception of Choosing Wisely many of the national specialty societies have joined the initiative. For a limited time, the Texas Medical Association (TMA) is offering a suite of Choosing Wisely webinars with continuing medical education credit at no cost.

Source: Texas Medical Association (TMA)

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**Virtual ICD-10 Training in Your Office**

With ICD-10 preparation well under way and the transition date just six months away, it’s time to determine how the new coding system will fit into your practice’s daily operations. How does your current documentation stack up to the new guidelines, and what changes do your staff members need to make to their standard workflow to ensure a seamless transition and steady payment flow? Your practice’s success is in the details.

TMA’s new seminar, streaming live over the internet, will train you and our staff in ICD-10 documentation and auditing. It will cover navigating the expansive ICD-10 CM code book, the new coding, guidelines, and avoiding denied claims through proper documentation and audit methods.

The live streaming seminar gives you the opportunity to ask questions and interact just as you would in person but without the travel. To register, visit the TMA Education Center or call (877) 880-1335.

Source: TMA

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**Should you outsource your billing?**

If you are currently processing your claims in-house to maintain control, you need to weigh the pros and cons and assess your cost:

- How many staff members are devoted to billing?
- What are you paying in salaries?
- What are your supply costs?
- How much experience do your billers have?
- Are your collections where they should be?

Right now, your number one consideration is ICD-10, which becomes effective October 1, 2015. Is your practice management system updated to handle the 141,000 codes? Do you know where to start? Do you have enough funds to off-set delays in payments?

A&W Healthcare billing service can counsel you so that you can make the right decision to help your practice grow. We will offer doctors (medical professionals) and group based health practitioners the ability to easily and affordably handle their billing needs. The benefits provided by A&W will allow the practitioner to perform their services without the hassle of having to deal with administrative tasks.

**Contact us today for your free consultation**

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CMS Rebuffs TMA’s Request to Drop Coercive MU Measures

The size of your next Medicare check could very well rest on whether you can get enough of your patients to email you; federal regulators believe that’s a sensible way to evaluate your meaningful use (MU) progress. In fact, if you can’t get more than 5 percent of your patients to send a “secure message using certified electronic health record technology (CEHRT),” you’ll not only lose eligibility for incentive pay, you’ll also be penalized.

Last November, TMA President Austin King, MD, asked the Centers for Medicare & Medicaid (CMS) to drop three measures in its Medicare electronic health record (EHR) incentive program that have nothing to do with clinical care or outcomes and over which physicians have no control. CMS said no.

In her response to Dr. King’s request, then-CMS Administrator Marilyn Tavenner agreed that the measures aren’t easy.

“We recognized the increased challenges associated with the patient engagement objective and its associated measures,” she said. “Therefore, we established a low threshold for these measures, recognizing that some measures under this objective require some direct action by the patient.” At issue are the measurements used in the program’s Stage 2 core objectives numbers 7 and 17, which are designed to encourage electronic interaction between physicians and patients. During a 90-day reporting period, physicians who are enrolled in the program must somehow show that more than 5 percent of their patients used the EHR either to look at their medical record online or download or send them to a third party. Another measure requires physicians to get more than 5 percent of their patients to send some kind of secure electronic message.

There’s no grading scale or bell curve applied in the Stage 2 assessment. You must achieve all 22 measures that make up the 17 objectives to qualify for incentive payments. Miss the mark on even one measure, and you’re not only disqualified for incentives but also slapped with a payment penalty.

It’s an unacceptable all-or-nothing approach, according to Dr. King, and it has no bearing on clinical outcomes. In his letter to Ms. Tavenner, Dr. King said that without evidence showing it improves outcomes, it’s unreasonable for CMS to base financial incentives or penalties on a physician’s ability to engineer patients’ online communication behavior.

“Many physicians treat elderly patient populations, and it is not reasonable to expect these patients to have access to a computer and the internet to download or transmit information, much less the desire to do so,” Dr. King said. “If CMS desires patients to behave a certain way, the incentives should be for those patients. It should not be required of physicians.”

The objectives can be especially onerous for physicians who see higher number of Medicare patients, 83 percent of whom are older than 65 years and 40 percent of whom are 75 or older, which is a demographic that is least likely to adopt technology. A 2012 Pew study showed that of persons aged 65 and older, 41 percent do not use the Internet at all, 53 percent do not have broadband access at home, and 23 percent do not use cellphones; starting at age 75, Internet use begins to drop significantly.

Dr. King had also asked that CMS work with Congress to suspend all MU physician penalties set to begin Jan. 1, 2015. “Physicians should not be penalized for not meeting virtually unattainable meaningful use measures,” Dr. King said. “The unintended consequence will be reduction in Medicare patients’ much needed access to care.”

In her reply, Ms. Tavenner said that because the penalties were established by statute, any changes must originate from Congress. “Further, we generally cannot suspend the current measures and objectives without notice and comment rulemaking,” Ms. Tavenner said. “Therefore, we cannot accommodate such requests.”

For more Medicare EHR incentive program information, visit TMA’s Medicare Resource page. For help with Medicare payment issues, email TMA Payment Advocacy, or call the TMA Knowledge Center at (800) 880-7955. TMA members can use the TMA Hassle Factor Log to help resolve insurance-related problems. Also, visit the TMA Payment Advocacy Services webpage and TMA’s Payer page for more resources and information.

Source: Action, March 16, 2015
Executive Board Actions

At its March 9th meeting, the Executive Board took the following action:

⇒ It was announced that Drs. Lloyd Stegemann and Jacob Moore will co-chair the 50th Annual Health Fair on August 1, 2015.

⇒ It was agreed to change NCMS fiscal year to correspond with the calendar year, effective Dec. 31, 2014.

⇒ David Petros, MD, Rheumatology; Randall Samberson, MD, General Surgery; Julian Sanchez, MD, Cardiovascular Diseases; Tomasz A. Wiraszka, MD, Ophthalmology; Sarah Withycombe, Pediatrics were approved for Active membership.

⇒ Nadine Aldahhan, DO, Jiten J. Bhula, MD, Scott E. Brunson, MD, Thomas A. Caton, MD, Leigh A. Collins, DO, James G. Colvin, MD, Kimberly Dabbos, DO, Grant R. Depoy, DO, Kayla L. Ehrman, DO, Maria A. Garcia, MD, Nicholas A. Harrell, MD, John Adam Hartman, MD, Zehra S. Hussain, DO, Joanne M. Knight, DO, Myra C. Liu, MD, Jessica A. Massey, DO, Mary M. Matthews, MD, Christopher S. Mock, MD, Jaime E. Moreno, MD, Ruchita S. Patel, MD, Susan Phan, MD, Emily P. Schmid, DO, Brady P. Simonak, DO, John P. Wenhold, DO were approved for Resident membership.

⇒ Pedro S. Diaz, MD, Obstetrics/Gynecology and Nabil El-Milady, MD, Obstetrics/Gynecology were approved for Life membership.

⇒ John Pettigrove, MD, Internal Medicine/Pulmonary Diseases was approved for Honorary Membership.

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You’re invited to the NCMS April Membership Meeting

Wednesday, April 8, 2015
Social at 6:15 pm
At Katz 21, 5702 Spohn Drive

Topic: “Reconstruction Options for the Pediatric & Adult Sarcoma Patient”

Speaker: Dr. Rajiv Rajani

Sponsor: Methodist Hospital Orthopaedic Oncology Program, San Antonio

Happy Easter
Medicare Corner

Analysis of CERT data – Common errors

Part B Comprehensive Error Rate Testing (CERT)
The most significant error for the fourth quarter 2014 was for insufficient documentation. The primary driver of these errors is missing the physician order or documentation of intent of ordering a laboratory or diagnostic test.

Independent labs and diagnostic testing facilities are responsible for providing the documentation to support services billed to Medicare. These providers often will request records from physician practices to support the billed services. As partners in patient care, it is important for physicians to comply timely with these requests. When sending documentation to third-party providers, keep in mind it should be complete, legible and should include at a minimum:

• Identity of person providing the service(s);
• Date of service;
• Patient’s signs and symptoms;
• Indication of where the services were provided;
• Signed orders for services and the clinical rationale for the orders; and
• Legible signature of person rendering the service and of the physician ordering the services. (If signature is not legible, submit a signature log, showing name in print and signature.)

Independent labs and diagnostic testing facilities also should include results of the tests performed. In addition to orders, another major drive of insufficient documentation is illegible signatures on documentation. Novitas and the CERT contractors may contact providers to obtain a signature attestation statement. Providers can assist in reducing errors by complying with these requests timely. Other errors to be aware of are:

• Incorrect coding of Evaluation and Management (E/M) services. These errors occur when the submitted documentation does not meet the code level reported on the claim. Coding errors represent significant dollars at risk;
• No documentation was received for the billed date of service as the provider stated patient was not seen on date of service; and
• Psychotherapy services were missing documentation of the duration of therapy.

Most common errors are:

• Error Code 21 – Insufficient Documentation;
• Error Code 31 – Incorrect Coding;
• Error Code 25 – Medical Necessity;
• Error Code 16 – No documentation received; and
• Error Code 98 – Span date error.

Source: Novitas Solutions

TMA Releases 2nd Edition of NPP Guide

Last year, the Texas Legislature passed legislation that replaces site-based requirements for the delegation and supervision of prescriptive authority for non-physician practitioners (NPPs) with a framework of delegation and supervision that uses customizable prescriptive authority agreements.

To reflect these recent changes in legislation, TMA has released an updated second edition of the best-selling publication Non-physician Practitioners: Hiring, Billing, and Delegation of Duties for a Non-physician Practitioner. The publication provides the most up-to-date, comprehensive information about the qualifications, supervision requirements, and practical aspects of contracting, credentialing, and billing for non-physician practitioners.

The prescribing of drugs and devices is a large part of the practice of medicine. While you may delegate the prescribing and ordering of drugs or devices to NPPs when appropriate, you must always supervise any delegation appropriately in accordance with the standard of care.

Source: Action, March 14, 2014
How long should employers keep employment records?

With all the changes in health care it is easy to lose focus on the fact that many physicians are small business owners and are required to maintain employee personnel files to ensure compliance with state and federal regulations. Employee personnel files include records such as, new hire paper work, employment history, achievements, disciplinary notices, promotions, performance improvement, accidents, benefits, and payroll records. It is important that these files are accurate and up to date to help protect against any potential claims, lawsuits, and/or audits by state or federal agencies. Below is a list of required timeframes that certain records should be maintained.

- New hire reporting – According to state law, all “new hires” must be reported to the Attorney General of Texas, within 20 days of hire.
- Hiring records – According to the Equal Employment Opportunity Commission (EEOC), employers are required to keep all new hire records for at least one year from the date the employee was hired; unless a claim or lawsuit was filed, then the employer must keep the records until the claim has been resolved.
- Employment eligibility verification – All employment eligibility documents, including the I-9 form must be kept for at least one year after the employee resigns.
- Payroll and unemployment records – According to the Fair Labor Standard Act (FLSA), most payroll records need to be kept for three years but, according to the Texas Unemployment compensation statute, these records are required to be kept for at least four years.
- Benefit and leave records – According to the Employment Retirement Income Security Act (ERISA) and the Health Insurance Portability Accountability Act (HIPAA), all benefit records such as, retirement and cobra benefits should be kept for at least six years.
- Disability related records – According to the Americans Disability Act (ADA), all documents related to the request for disability accommodations must be kept for at least one year from the date the request was made or from the date the request was granted.
- Personnel action records – According to the Age Discrimination Employment Act (ADEA), all documents related to personnel actions should be kept for at least one year. If a claim or lawsuit was filed then the employer must keep the records until the claim has been resolved.
- Work related injury records – According to Occupational Health and Safety Administration (OSHA), employers are required to keep all work related injury reports for at least five years.

Source: Texas Work Force Commission

Questions to ask a billing company

Before you decide to hire a medical billing company, you should consider asking the following 10 questions:

- What type of training does the staff have? Are they certified coders? What type of ongoing training does the staff receive? Does the office incorporate the most current coding books and guidelines?
- Is your billing company HIPAA compliant? Ask to see a copy of their compliance plan and confirm who at the billing company is the HIPAA security officer?
- Does the billing company have a current billing policy? Does the billing policy identify how denials will be worked? Does the policy outline the frequencies in which patient statements will be sent out? Confirm who owes the billing data.
- Does the billing company have a process in place to ensure claims are being paid at the contracted rate?
- What types of reports will be given, how often, and how are special request reports handled?
- Does the billing company have experience billing for your specialty?
- Does the billing company perform chart audits? Is there an additional charge for this service? How frequently are chart audits performed and will the finding be shared with the physician?
- Does the billing company have references that can be contacted?
- What is the cost for the billing company’s services? Will the fee be based upon a percentage of collections or will it be based upon a flat rate?
- Will the above components be included in the contract?

Source: Physician Practice
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April 2015
Nueces County Medical Society
Save the dates!

April Membership Meeting, April 8th at Katz 21
50th Annual NCMS Health Fair, Saturday, August 1, 2015

ACLS Renewal & Provider Courses

The South Coastal Area Health Education Center (AHEC) will sponsor the next ACLS 2 Day Provider/Renewal Course on Friday and Saturday, April 4-5, 2015. The courses will be held at CHRISTUS Spohn Corpus Christi Memorial Hospital. Check-in begins at 7:30 a.m.

The Renewal Course is 8 am - 12 pm on Saturday. Registration fee covers the updated AHA/ACLS Provider Manual, study materials, refreshments, continental breakfast and lunch. Attendees must present a current ACLS card at the door for verification upon check-in.

The Combined BLS/ACLS Renewal Classes is April 5, 2015 at 10am.

The South Coastal Area Health Education Center is accredited by TMA to sponsor CME for physicians and designates this activity as meeting the criteria for 16 credit hours in Category 1 of the PRA of the AMA.

Contact, Mary Moreno: mmorenogcahec@yahoo.com or Joanne: (361) 881-8133.

Or you can register online at: http://www.scahec.com/content.html

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Medicare /Medicaid Corner

Dual Eligible Pilot Enrollment Starts April 1

Patient enrollment in the Texas Health and Human Services Commission’s (HHSC’s) six-county Dual Eligible Integrated Care Demonstration Project begins April 1. The project is a partnership between Texas and the Centers for Medicare & Medicaid Services (CMS) to test a new model for providing coordinated care to patients enrolled in both Medicare and Medicaid. Texas and CMS will contract with Medicare and Medicaid managed care plans to coordinate patient care across both programs.

Nationwide, more than 9.6 million seniors and people with significant disabilities are dually eligible for both programs, and as many as 20 million of them may be included in the demonstrations. Often, medically fragile, dual-eligible patients are typically poorer and sicker than other Medicare beneficiaries and use more health care services.

The project’s objectives include:

- Making it easier for clients to get care,
- Promoting independence in the community,
- Eliminating cost shifting between Medicare and Medicaid, and
- Achieving cost savings for the state and federal government through improvements in care and coordination.

More than 165,000 Texas patients in Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant counties qualify for the program and may eventually be covered under the new plan; only patients who opted into the program were enrolled in March.

Patients will be included in the project if they:

- Are age 21 or older;
- Get Medicare Parts A, B, and D, and are receiving full Medicaid benefits; and
- Are in the Medicaid STAR+PLUS program, which serves Medicaid clients who have disabilities or get STAT+PLUS Home and Community Based Services waiver services.

In the demonstration, health plans must provide the full array of Medicaid and Medicare services. This includes any benefits that will be added to the STAR+PLUS service array by March 1, such as nursing facility services, psychosocial mental health rehabilitation, and targeted case management.

Passive enrollment will begin in April and progress incrementally through August and will apply to 20 percent of non-facility patients within a county by ZIP code. For example, all dual eligible patients eligible for passive enrollment who live in a pilot county and who are in cohort 1 ZIP codes, will be passively enrolled on April 1 unless they opted out. Enrollment of dual-eligible nursing facility patients will begin Aug. 1 in Bexar and El Paso counties, followed by Harris County nursing facility patients on Sept. 1 and those in remaining counties on Oct. 1.

Passive enrollment will begin in April and progress incrementally through August and will apply to 20 percent of non-facility patients within a county by ZIP code. For example, all dual eligible patients eligible for passive enrollment who live in a pilot county and who are in cohort 1 ZIP codes, will be passively enrolled on April 1 unless they opted out. Enrollment of dual-eligible nursing facility patients will begin Aug. 1 in Bexar and El Paso counties, followed by Harris County nursing facility patients on Sept. 1 and those in remaining counties on Oct. 1.

HHSC has developed a detailed enrollment grid by county to help practices better understand how patients will be assigned to a plan.

Patients may elect to opt out before the pilot begins. If a patient opts out after being enrolled in a plan, then the change will take effect the first of the following month. Physicians cannot steer patients to a particular managed care plan, but can inform patients about the demonstration plan(s), if any, in which they participate. Patients who opt out may also later opt back in.

Patients Still Have a Choice

Patients eligible for the demonstration will be sent introduction letters 90 days before enrollment and additional reminder letters 60 days and 30 days before passive enrollment begins. If a patient is enrolled in a plan whose network does not include their physician(s), continuity of care must be protected for the first 90 days.

Specifically, the contract between CMS, HHSC, and the plans specifies that a patient’s care must not be disrupted when the patient enrolls in a plan: “The STAR+PLUS Medicare and Medicaid Plan (MMP) allows enrollees receiving any services at the time of enrollment to maintain their current providers, including with providers who are not part of the STAR+PLUS MMP’s network, and service authorizations, including drugs, for at least up to ninety (90) days after the enrollee’s enrollment effective date or until the Plan of Care and/or ISP are updated and agreed to by the enrollee, whichever is earlier.”

The contract further states that the STAR+PLUS MMP must ensure continuity of care for new enrollees whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

Visit the HHSC or CMS websites for more information about the project, including the Texas proposal and memorandum of understanding.

To see how CMS will monitor and evaluate the Texas demonstration project, read Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals.

Continued on next page
Medicare /Medicaid Corner continued from page 11

HHSC website resources include:

- Cohort ZIP Code List,
- Dual Eligible Pilot Provider Training,
- Enrollment Information
- Contract Requirements, and
- Memorandum of Understanding.

Training Webinar Archive:

Texas Dual-Eligible Integrated Care Demonstration Project, Jan. 21, 2015
You must register with Citrix to view this archive. To learn about this archive in other formats, email Health Kuhlman at HHSC.

Source: Action, March 16, 2015

Marketplace special enrollment period opened

The Centers for Medicare and Medicaid Services (CMS) recently announced that a special enrollment period is now available from March 15 to April 30, 2015, for individuals who were unaware of the tax penalty regarding health care coverage. It is estimated that more than six million people owe a tax penalty. These individuals will be eligible to attest that they were unaware of the tax penalty and will be eligible for the special enrollment. However, these individuals will still be subjected to the 2014 tax penalty for not having healthcare coverage. The fee for not having coverage in 2014 is $95 a person or 1% of annual household income, whichever is greater. The fee for not having coverage in 2015 is $325 per person or 2 percent of the household income, whichever is greater.

Source: CMS

April Calendar

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<tr>
<th>Date</th>
<th>Event</th>
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<tr>
<td>Fri 4/3</td>
<td>Good Friday, NCMS office closed</td>
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<td>Sun 4/5</td>
<td>Easter</td>
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<td>Tues 4/7</td>
<td>First Tuesday in Austin</td>
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<tr>
<td>Wed 4/8</td>
<td>NCMS Membership Meeting, 6:15 pm at Katz 21</td>
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<td>Fri 4/10</td>
<td>Health Fair Committee, NCMS building 7:45 am</td>
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<tr>
<td>Mon 4/13</td>
<td>Editorial Board 12:30 pm NCMS office</td>
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<td>Mon 4/13</td>
<td>Executive Board Meeting, 6pm</td>
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<td>Wed 4/15</td>
<td>TAX Day</td>
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<td>Tues 4/21</td>
<td>Board of Censors, 5 pm NCMS office</td>
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<td>Wed 4/22</td>
<td>Earth Day</td>
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<td>Thurs 4/23</td>
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“Save the Date”
August 1, 2015
50th Annual Health Fair
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Nueces County Medical Society
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Exhibit Hall
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TexMed 2015: Come to Austin for fun, education and CME

Thousands of your colleagues will be in Austin to experience TexMed 2015, and there’s no better opportunity to meet, network, or just get together to have some fun. Activities in the Expo Hall, networking lunches, local attractions, and the 22nd annual TMA Foundation Gala all offer a wonderful chance to strengthen your bond with other Texas physicians. From practice management to holistic medicine, TexMed 2015 is packed with a variety of continuing medical education (CME) tracks – some 80 hours in total.

Register today for Texas Medical Association’s (TMA) free annual conference, and join thousands of fellow Texas physicians when TexMed 2015 descends on the Austin Convention Center and Hilton Austin May 1-2 for a weekend of advocacy, education, and collaboration. TexMed is TMA’s largest event of the year. Arrive early on Thursday, April 30, and bring your white coat for TexMed at the Capitol! Head to the Capitol and visit with legislators and key staff. You will have the opportunity to meet with elected officials face-to-face to urge support for medicine’s priorities this legislative session. Join other physicians and Alliance members to make a big impression! TMA will provide a shuttle between the Capitol and the Hilton for your convenience.

For a little something different, view the latest in quality improvement initiatives by visiting the third annual TexMed Poster Session on Saturday from 8 to 9 am. Categories have been expanded this year to offer physicians and medical practice staff more opportunities to participate. For more info or to submit an application, visit www.texmed.org/QualityPosters. Abstract deadline is March 27. Physicians and medical professionals will have the chance to share their successes and breakthroughs in improving patient care with their peers from around the state. This will be a great opportunity for participants to not only report on their quality improvement methods and best practices, but also to gain inspiration from their colleagues’ approaches to providing quality patient care, and to identify new quality improvement techniques to take back and implement in their own practices.

On Saturday at the Closing General Session, Patricia A. Shands, MD, will share her unique journey through health care. An orthopedic surgeon, Dr. Shands lives and works in Anchorage and for the Alaska Native Tribal Health Consortium. Her stirring speech recounts her work with Native/Inuit tribes at the hospital and in their remote villages, offering an extraordinary look at the path down which medicine has taken her.

Drs. Michelle A. Berger and David N. Tobey of Austin and Drs. Harry T. Papaconstantinou and Susan M. Pike, Georgetown will co-chair this year’s Gala, A Lawn Party. The stylish garden gathering will be held at the Hilton Austin at 7 p.m. on May 1 and features dinner, entertainment, and live auction. More than 500 physicians, their spouses, guests, and friends of medicine are expected to attend. Purchase tickets online at www.texmed.org/foundation, or call (8800) 880-1300k, ext. 1664.

For a full schedule of events, CME, exhibitors, lodging information, and fun things to do in and around Austin, visit www.texmed.org/texmed. Be sure to register today to reserve your spot so you can enjoy this free benefit of your TMA membership.

Social & networking for Physicians

Mark your calendar for an evening filled with fun, food, drinks, networking and education. Don’t miss the Nueces County Medical Society (NCMS) social hour and membership meeting on Wednesday, April 8, at Katz 21.

The networking and social hour are from 6:15-7 p.m., followed by dinner, a brief business meeting, and the educational program, “Reconstruction Options for the Pediatric & Adult Sarcoma Patient,” presented by Dr. Rajiv Rajani, Orthopaedic Oncologist, Methodist Hospital Orthopaedic Oncology Program, San Antonio, TX. There is no cost for NCMS members attending; cost for retired members/spouses/guests is $25.

To register for the event, contact Sandra Montemayor at 884-5442, or email smontemayor@nuecesmedsociety.org. Methodist Hospital, San Antonio, TX is sponsoring the event.

Under the Rotunda with TMA Legislative News Hotline

The Texas Legislature is in full swing. Watch the TMA Legislative News Hotline video of TMA’s Vice President of Advocacy Darren Whitehurst as he describes the new leadership at the Capitol and the issues TMA is working on during the 84th legislative session.

What happens at the Texas Capitol between now and June 1 can have a profound effect on what happens in your practice for many years. With TMA Legislative News Hotline, you get daily, weekly, or both updates on the progress of the state budget and bills that promote or hinder our Healthy Vision 2020 agenda.

If you’re not already subscribed, sign up for Hotline today at www.texmed.org/hotline. It’s your finger on the pulse of your future.
Save the Date(s) for First Tuesdays

The “White Coat Invasion” has been the key to physicians’ successes in the Texas Legislature since the inception of First Tuesdays at the Capitol in 2003. Our senators and representatives listen when their hometown doctors appear in their offices. Our influence is so much greater when physicians and alliance members arrive en masse in the House and Senate galleries. It’s time again to bring out Texas medicine’s strongest weapon.

Mark your calendar for the remaining 2015 First Tuesdays at the Capitol, and register today:

- April 7 and
- May 5.

Although the Texas Legislature is becoming more hyper-partisan and hyper-political, TMA will continue to work for what’s best for patients and their physicians. Medicine’s 2015 legislative agenda, based on TMA’s *Healthy Vision 2020, Second Edition* will focus on:

- Increasing funding for graduate medical education.
- Improving physicians’ Medicaid and CHIP payments to more appropriately reflect the services they provide to patients.
- Holding health insurance companies accountable for creating and promoting adequate physician networks.
- Devising and enacting a system for providing health care to low-income Texans that improves efficiencies by reducing bureaucracy and paperwork.
- Stopping any efforts to expand scope of practice beyond that safely permitted by non-physician practitioners’ education, training, and skills.
- Promoting government efficiency and accountability by reducing Medicaid red tape.
- Protecting physicians’ ability to charge for their services.
- Improving the state’s public health defense to better respond in a crisis.
- Preserving Texas’ landmark medical liability reforms.
- Protecting the patient-physician relationship from corporate intrusions.

*Source: Action, March 16, 2015*

More efficient compliance reporting

Current quality initiatives such as Physician Quality Reporting System (PQRS), Meaningful Use (MU), programs for commercial payers, and physician specialty board certifications are misaligned and frequently require redundant reporting. This disconnect between the various programs increase administrative burdens on practices and takes time away from patient care. In addition, the quality measures used are often not appropriate or pertinent for the different specialties. Therefore, a network of specialty specific registries, such as the National Quality Registry Network® (NQRN) may be able to align and connect these disparate programs.

The NQRN is a voluntary network of organizations operating registries (e.g., specialty societies) and others interested in increasing the usefulness of clinical registries to measure and improve patient health outcomes. The NQRN envisions a national network where information from registries, health insurance claims data and reference data sets from the federal government (e.g., census databases) can be linked together to examine questions that cannot be addressed using registry data alone.

Beginning in 2014, the Centers for Medicare and Medicaid Services (CMS) also created a new PQRS reporting pathway that enables approved registries (e.g., specialty societies) to submit both non-PQRS and PQRS measures to CMS. This method currently known as Qualified Clinical Data Registries (QCDRs) enables physicians in specialties and subspecialties to report measures that are more pertinent and meaningful to their specialty. According to a list compiled by the American Medical Association (AMA) in 2015, there are approximately 108 different registries. In 2014, 36 of these registries successfully qualified as QCDRs.

It is important that physicians lead quality initiatives so that quality measurements will be streamlined across all payers and implemented to truly reflect good patient care.

*Source: American Medical Association (AMA) & Centers for Medicare and Medicaid Services (CMS)*

Pick up your 2014-2015 NCMS Pictorial Directory at the NCMS office, 1000 Morgan. Members receive one free copy, each additional copy is $20.00.
TMA CME: Put your Practice on the Social Media Map

It’s a digital world – is it time for you to get your practice “out there” via social media? Meet the public in their favorite digital hangouts. Register today for the Texas Medical Association (TMA) course, Get Social: Put Your Practice on the Social Media Map, from Texas Medical Liability Trust.

Get Social is primarily for physicians who have no professional experience using social media. It offers you a road map for that first tentative drive onto Twitter, for that first Sunday excursion to Blogland, for that first high-speed adventure along Interstate YouTube. Physicians and practices that already have begun the trip and are looking to improve their social media mileage are certainly welcome to join along as are those of you who already engage these networks in your personal life.

This book is not a technical guide to setting up accounts or pages. It is about you and your practice and your patients, and how you can make these tools help you do a better job of building your practice. It is about putting your practice on the social media map, while avoiding HIPAA potholes and other detours.

This course offers 1.75 AMA PRA Category 1 Credits™, with 1.75 credits in medical ethics and/or professional responsibility as well as 1.75 credits for TMLT. Physicians who are insured with Texas Medical Liability Trust (TMLT) may earn professional liability insurance discounts by participating in approved continuing education activities. TMLT policyholders who earn three TMLT credits within 12 consecutive months will earn a three-percent discount (not to exceed $1000), which will be applied to their next eligible policy period.

The cost is $39 for TMA members and $80 for non-members. To learn more information about this course, go to texmed.inreachce.com/ and select Communications/Get Social: Put Your Practice on the Social Media Map. Participants earn CME by reading the course in its entirety and completing a post-test and course evaluation to obtain credit.

Source: TMA

“Ask the Doctor”

We need YOU on Wednesdays in April and May!

Please sign up for a very interesting and fun hour; it’s a great way to publicize your practice!

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Interested in volunteering to lead a session?

Have a topic that really interests you?

Call 884-5442 or email Susan today to get your session scheduled!

PLEASE PRINT YOUR NAME: ____________________________________________

PREFERRED MODE OF CONTACT:

PHONE __________________ OR EMAIL __________________

Fax form to: (361) 884-5478 or email form to: sdavis@nuecesmedsociety.org
Diamond
CHRISTUS Spohn Health System

Platinum
Radiology Associates
Radiology and Imaging of South Texas
Texas Medical Liability Trust

Gold
Texas Medical Association Insurance Trust
American Bank

Silver
TheDoctorsCompany
ProAssurance
Methodist Hospital of San Antonio
Corpus Christi Medical Center
Driscoll Children’s Health Plan
The Children’s Clinic
Texas Medical Association

Bronze
Humpal Physical Therapy
South Texas Brain and Spine, P.A.
Heavin & Associates
Driscoll Children’s Hospital
Coastal Bend Blood Center
Coastal Bend Eye Center
Hearing Aid Company of Texas
Neonatology Consultants of Corpus Christi
Nurses on Wheels, Inc
True Medical Imaging
South Texas Bone & Joint
ONYX & GILEAD Pharmaceuticals
Bay Area Citizens Against Lawsuit Abuse
Surgical Associates
The Plaza at Mirador

FRIENDS OF THE SOCIETY
The Nueces County Medical Society (NCMS) established Friends of the Society to invite businesses that serve physicians the opportunity to support NCMS and increase their visibility among NCMS members. Corporate support of NCMS contributes to its ability to advocate and care for physicians and patients in Nueces County. NCMS thanks these organizations who are Friends of the Society.

Please consider these organizations for your practices. For information about their products and services, go to www.nuecesmedsociety.org and click on the Friends of the Society tab at the top of the page. Participation in Friends of the Society does not constitute an endorsement by NCMS of the participating organizations or the organizations’ products and services.