

Healthcare Organizations:
[Journal of Financial Management Strategies]
August 2010 Newsletter



MID-YEAR GREETINGS AND SALUTATIONS

In response to, among other things, the Patient Protection and Affordable Care Act [PPACA] that was signed into law earlier this year, the Centers for Medicare and Medicaid Services (CMS) issued an interim final rule on May 5, 2010 that requires all:

- Physicians and non-physician practitioners who order or refer Medicare beneficiaries for, or furnish Medicare beneficiaries with, Part B covered items and services; and
- Physicians who certify home health services be enrolled in PECOS as of July 6, 2010 in order for the billing provider to receive payment for the ordered, referred, or furnished items or services under Medicare Part B (and, in the case of home health services, Part A). Some of the types of claims that will be affected by this new rule include:
 - Claims from laboratories for ordered tests;
 - Claims from imaging centers for ordered imaging procedures;
 - Claims from suppliers of DMEPOS for ordered DMEPOS;
 - Certification for Part A and Part B covered home health services; and
 - Claims from specialists or specialty groups for referred services (including, but not limited to, physical therapy services).

In addition to prohibiting payment for these services, the interim final rule also requires that the teaching physician — NOT the intern or resident — be identified on the claim for Part B services as the referring or ordering physician whenever an intern or resident orders or refers. This is also effective as of July 6, 2010.

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Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act were enacted into law back on October 8, 2008. This act will end health insurance benefits inequity between mental health/substance use disorders and medical/surgical benefits for group health plans with more than 50 employees. The regulations that guide implementation of this law were effective for health plan years beginning on or after July 1, 2010. These regulations have significant implications for providers of mental health services, payers, employers, and consumers.

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Fraternally,

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Pay-for-Performance Dentistry

For journal readers and subscribers who are interested in how quickly quality assessment of dental care in the nation is progressing, a paper was posted on 7th Space titled "Pay for performance, by Andreea Voinea-Griffin et al, follows

http://7thspace.com/headlines/342745/pay_for_performance_will_dentistry_follow.html

The paper begins: "... *Pay for performance*' is an incentive system that has been gaining acceptance in medicine and is currently being considered for implementation in dentistry. However, it remains unclear whether pay for performance can effect significant and lasting changes in provider behavior and quality of care ..."

Andreea Voinea-Griffin et al, have no idea.

The clueless authors then explore only a few of the factors that they determined complicate the national adoption of carefully planned, "value-based purchasing programs" in dentistry that are designed by software experts to replace the uncontrollable, low-tech free market system based on finicky, uninformed patient preferences. After all, depending on "gut feelings" about one's healthcare provider is tens of thousands of years old and hardly scientific.

Stakeholders both inside and outside our own ADA – many of whom lead in the promotion of Evidence-Based Dentistry – feel that dental patients need government help to not only distinguish a good dentist from a bad dentist, but to save everyone money in dental care by forcing dentists to provide the highest possible quality for the lowest possible price.

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Without even mentioning how revolting their system will be to thinking Americans, here are some of the complicating factors that the authors cite which they say still must be overcome before the dental market can be controlled by computer experts for the common good:

- Variations in dental care
- Lack of development for evidence-based dentistry
- Scarcity of outcome indicators
- Lack of clinical markers
- Inconsistent use of diagnostic codes
- Scarcity of electronic dental records.

Do you see how ADA-approved evidence-based dentistry, ADA-approved coding and ADA-approved electronic dental records all play important rolls in the quality-controlled dental market of the future? Even though you won't be able to get an ADA official to discuss their eDR plans with you unless you are a fellow officer or stakeholder, our dues are quietly funding the development of pay-for-performance in the nation.

Let me ask you something, dentists. Do you have an NPI number? Did you ever wonder about the real purpose of the permanent 10 digit number that the ADA Department of Dental Informatics persuaded you to volunteer for, but was reluctant to discuss? When your ADA leader assured you that signing up for the NPI was the right thing to do, I bet you trusted him, didn't you. Will you ever trust him again, or did he blow it by betraying your trust?

The authors conclude: "Although none of these factors were essential deterrents for the implementation of pay for performance programs in medicine, the aggregate seems to indicate that significant changes are needed before this type of program could be considered a realistic option in dentistry." And American dental patients' welfare is protected from e-Avarice for a little longer.

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I couldn't help but notice that among Voinea-Griffin and her 5 cohorts, not one thought to mention tens of thousands of other tricky problems with their plans for a perfect society – dentists can be real bastards if some bozo threatens the welfare of their trusting patients. Just try it.

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THE END

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