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Medicare Crisis Averted but Problems Persist

In a last ditch attempt to "fix" the physician fee schedule problem that resulted in a possible 4.4% reduction in the Medicare physician fee schedule, Congress, as part of the Omnibus FY 2003 Appropriations bill, authorized CMS to "fix" the problem. As a result of this solution, CMS has announced (previously reported) that instead of a 4.4% reduction, physician's on average, would experience a 1.6% increase effective for services delivered after March 1st. While this was welcome news for the physician community, the good news was soon followed by the proverbial bad news. Due to a technological problem, CMS has announced that all claims for services provided in January and February but submitted in March will be paid at the higher post-March 1 rates even though those services are not entitled to the higher rate. This means that CMS will undertake to recoup these overpayments, most likely in July.

HBMA has been in contact with CMS officials to see if there are alternatives to this cumbersome and costly process.

2003 Medicare Physician Fee Schedule

Revised national physician fee schedule payment amounts are available in a downloadable file
at: http://cms.hhs.gov/providers/pufdownload/default.asp#pfspayment

These fee schedule amounts are based on the Medicare Physician Fee Schedule Final Rule published on 2/28/03.

Medicare Reform?

While much of our nation's attention has been focused on events in the Middle East, the Bush Administration's domestic advisers and the Congressional Leaders continue to work on Medicare reform legislation. The first step in that process will be the adoption of a Budget Resolution that would authorize the spending necessary to achieve meaningful reform. President Bush has requested $400 Billion in new Medicare spending be authorized over the next 10 years. It appears likely that Congress will approve this budget authorization. However, what is not clear is whether there will actually be $400 billion to spend. According to some budget analysts, the physician fee schedule fix (story above) will cost $50 Billion in new Medicare spending over the next 10 years. As this figure was not anticipated in the 2003 budget, some are arguing that this $50 billion should be accounted for in the reform proposal thereby leaving "only" $350 billion to

spend on other reform initiatives.

Rather than providing specific details for Medicare reform, President Bush has submitted an outline of his ideas with an expression of a willingness to work with Congress on the details. If you would like to view the Bush Medicare Reform Framework, go to:

www.whitehouse.gov/news/releases/2003/03/20030304-1.html

or view a copy of the speech President Bush delivered to the American Medical Association announcing the plan, go to:

www.whitehouse.gov/news/releases/2003/03/20030304-5.html

According to the White House, the following are the guiding princples behind the President's proposal:

1. All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.

2. Modernized Medicare should provide better coverage for preventive care and serious illness.

3. Beneficiaries should have the option of keeping the traditional plan with no changes.

4. Medicare should provide better health insurance options, like those available to all federal employees.

5. Medicare legislation should strengthen the program's long-term financial security.

6. The management of the government Medicare plan should be strengthened so that it can provide better care for seniors.

7. Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.

8. Medicare should encourage high-quality health care for seniors.

Congressional Democrats also announced their principles for Medicare reform. In early January, the Senate Democrat leadership introduced S. 7, the Prescription Drug Benefit and Cost Containment Act of 2003. To view a copy of this bill, go to:

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:s7is.txt.pdf

If you would like to see a brief description of the underlying principles behind the legislation, go to: http://democrats.senate.gov/~dpc/pubs/108-1-18.html

Regardless of your opinion on the various Medicare reform initiatives, you are strongly encouraged to contact your federal elected officials and communicate your views.

It should be noted that regardless of the various benefit or service delivery changes that may or may not be part of a Medicare reform initiative, it is expected that the final bill will include the long awaited Medicare administrative reforms HBMA has been supporting for several years.

Congressional action on the budget will likely occur in late March and early April with the prospect for Medicare reform being before the Congress in May.

Medicaid Reform

On the heals of announcing their long awaited Medicare reform proposal, the Bush Administration also announced plans to seek reforms in the Medicaid program as well. Unfortunately, little in the way of details was available at the time this article was being written. During various interviews and press conferences, Administration officials from HHS Secretary Tommy Thompson to CMS Administrator Tom Scully have said that the proposal involves giving states greater flexibility with respect to "optional" services and populations.

In exchange for giving the states this flexibility, the Bush Administration proposes investing billions of additional dollars in the Medicaid program over the next few years. The response in Congress to the proposal has been lukewarm at best. Many, including senior Republicans, have questioned the idea of increased state flexibility. Presently the federal government funds Medicaid to the tune of approximately 55% of program costs. For some states, the federal contribution is close to 70% of program costs. Those opposed to the idea of expanded flexibility argue that because the federal government is funding the bulk of the program, the federal government should have some say in how the money is being spent.

There is no question that the states need more money to keep their Medicaid programs afloat. Some in Congress are arguing that the federal government should simply provide a temporary increase in the federal Medicaid allocation without loosening federal oversight. Critics of the President's proposal have called it a block grant. This is an approach first used by former President Richard Nixon in the early '70s in which the federal government made broad, generally unrestricted, grants to the states. These were effectively "no strings attached" transfers of federal dollars to the state treasuries. Bush administration officials deny that this new Medicaid proposal is a block grant. In response to this criticism, both CMS Administrator Tom Scully and HHS Secretary Tommy Thompson have become very irritated at the mere suggestion that this is a block grant.

It is not clear how far this proposal will go and a great deal depends on the specifics of the

plan.

Medicare Enrollment Questions - See you in Las Vegas

The Centers for Medicare and Medicaid Services has approved the travel for a representative of the CMS office of Provider Enrollment to attend the HBMA meeting in Las Vegas. In addition to providing an update on changes to the enrollment process and responding to your questions, Patti Snyder will present the Top 10 most common problems Medicare Carriers find with the enrollment forms.

HIPAA Session On Tap

Plans are also underway to have two senior CMS officials present on HIPAA transaction standards, during the Las Vegas meeting. However instead of being on-site, the presenters will be beamed in from CMS headquarters in Baltimore, Maryland. These officials will talk about the roles and responsibilities of billing companies under the new transaction standards, the differences between a billing company and a clearinghouse when it comes to HIPAA, transaction requirements and CMS plans for enforcement of the new requirements.

Rehnquist Leaving IG Post

HHS Inspector General Janet Rehnquist has announced her resignation to "spend more time with my family". Rehnquist's tenure has been controversial almost from the start of her time in office. The daughter of Supreme Court Justice William Rehnquist, her confirmation hearing was frought with high drama and political overtones not normally associated with an Inspector General nominee.

Rehnquists management style angered many senior IG employees resulting in nearly 20 retirements or resignations by experienced auditors during her first year in the IG position. This type of loss among senior officials within a single agency caused great concern on Capitol Hill, particularly among those elected officials who have made a career of fighting fraud and abuse.

While no permanent replacement for Rehnquist has been announced, it is expected that there will be considerable Congressional pressure to appoint a very tough, aggressive person to the position. Former President Ronald Reagan once said he wanted his IGs to be as tough as "junkyard dogs".

Senator Chuck Grassley, Chairman of the Senate Finance Committee had this to say about the Rehnquist resignation, "This is the right step. The inspector general job wasn't a good fit for her abilities. I certainly wish her well in her next position. It's very important that we get a bulldog for the taxpayers on the job in the HHS IG office right

away. The department handles $530 billion in spending every year. I intend to be very involved in determining who will be taking over."

According to a press release issued by Senator Grassley, he requested the General Accounting Office conduct a review of whether significant personnel changes at the IG's office would result in weaker policing of health care fraud. This indicates that Senator Grassley has been briefed by the GAO on its findings. There is strong speculation that the GAO findings, which have not been publicly released, played a major role in Rehnquist's decision to resign.

Program Memos Issued by CMS

The following are Program Memos issued by CMS from January 1 through January 31st. These issuances are official agency transmittals used for communicating reminder items, requests for action or information of a one time only, non-recurring nature. To obtain a
link to any of these documents, go to:

http://www.cms.gov/manuals/memos/comm_date_dsc.asp

Policy Number	Description	Effective Date
A-03-018	Installation of Version 28.0 Second Add-On of the Provider Statistical and Reimbursement (PS&R) Report	3/31/2003
B-03-021	Provider Education Regarding Home Health Consolidated Billing (HH CB) and Provider Liability	3/7/2003
AB-03-035	Emergency Changes to the 2003 Medicare Physician Fee Schedule Database	3/3/2003
B-03-020	2003 DMEPOS Jurisdiction List	4/1/2003
AB-03-031	Addition or Modification of Temporary "K" Codes and Change in Status for Code A4232	4/1/2003
B-03-017	Add-On-Codes for Anesthesia	7/1/2003
B-03-018	Changes to Correct Coding Edits, Version 9.2, Effective July 1, 2003	7/1/2003
AB-03-030	Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 1, 2003	4/1/2003
Policy Number	Description	Effective Date

AB-03-024	Clarification of the Allocation of Initial Claim Entry Activities Where the Claim is Paid Secondary by Medicare.	4/12/2002
A-03-016	Continuous Home Care Under Medicare Hospice	4/1/2003
AB-03-028	Coverage and Billing of Sacral Nerve Stimulation	1/1/2002
B-03-019	Durable Medical Equipment Regional Carriers (DMERCs) and Part B Carriers on the VMS Standard System—Short Descriptions of National Modifiers on the Healthcare Common Procedure Coding System (HCPCS) Tape	7/1/2003
A-03-015	Electromagnetic Stimulation	4/1/2003
AB-03-032	File Names, Descriptions and Instructions for Retrieving the 2003 Ambulatory Surgical Center (ASC) HCPCS Additions, Deletions and Master Listing	4/1/2003
AB-03-029	Health Care Claims Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277	3/28/2003
AB-03-034	Medicare Fee for Service Contractor Guidance on the HIPAA Privacy Rule	4/14/2003
AB-03-027	Payment Change for the 2003 Medicare Physician Fee Schedule (MPFS) and Further Extension of the 2003 Participation Enrollment Process	3/1/2003
A-03-017	Payment for Services To Be Paid on a Fee Schedule But For Which There Is No Price--ACTION	3/14/2003
AB-03-033	Promoting Colorectal Cancer Screening as a Part of National Colorectal Cancer Awareness Month	3/10/2003
AB-03-025	System Networking Electronic Correspondence Referral System (SNECRS) 1.3 User and Installation Guides for Testing and Production	10/8/2002
A-03-014	Further Guidance Regarding Billing Under the Outpatient Prospective Payment System (OPPS)	8/1/2000
AB-03-026	Implementation of the Modifications (4010A1) to Transactions and Code Set Standards for Electronic Transactions Adopted Under the Health Insurance Portability and Accountability Act (HIPAA)	4/1/2003
A-03-013	3-Day Payment Window Refinements Under the Short-Term Hospital Inpatient Prospective Payment	7/1/2003

	System	
Policy Number	Description	Effective Date
AB-03-021	Additional Documentation Requests (ADR) Requirements for Ordering Providers of Laboratory Services	7/1/2003
A-03-011	Changes in Payment for Certain Services Provided by Outpatient Physical Therapy (OPT) Providers Under the Medicare Physician Fee Schedule (MPFS)	7/1/2003
AB-03-020	Clarification of Transmittal AB-00-107, Change Request 1163, and Transmittal AB-00-129, Change Request 1460, Regarding the Coordination of Benefits (COB) Contractor and Medicare Secondary Payer (MSP) Prepay Work Activities for Customer Service, MSP and Standard Systems Contractor Staff	2/15/2001
AB-03-023	Deep Brain Stimulation for Essential Tremor and Parkinson's Disease	4/1/2003
A-03-010	Manual Medical Review Indicator for the Comprehensive Error Rate Testing (CERT) Program	7/1/2003
A-03-012	The Report of Benefit Savings (RBS)	3/31/2003
AB-03-022	Use of the American Medical Association's (AMA's) Physicians' Current Procedural Terminology, Fourth Edition (CPT) Codes on Contractors' Web Sites	See PM
AB-03-019	Notice of Interest Rate for Medicare Overpaymentsand Underpayments	2/11/2003
B-03-013	Continuation of April 2003 Change Request 2424: Create Import/Export Functionality Between the Unique Provider Identification Number System (UPIN) and the Provider Enrollment Chain Ownership System (PECOS)	7/1/2003
B-03-014	Continuation of April 2003 Change Request 2425: Create Import/Export Functionality Between the Medicare Claims System (MCS) and the Provider Enrollment Chain Ownership System (PECOS)	7/1/2003
B-03-015	Continuation of April 2003 Change Request 2426: Process all Medicare Part B Provider Enrollments in the Provider Enrollment Chain Ownership System (PECOS). Modify the Medicare Claims System (MCS) to Incorporate All Claim Payment and Provider Correspondence Functionality That is Included in the Carrier Provider Enrollment System (PES) But Will Not Be a Part of PECOS. Shut Down All	7/1/2003

	Provider Enrollment Functions in PES	
Policy Number	Description	Effective Date
B-03-016	Continuation of April 2003 Change Request 2427: Process all Medicare Part B Provider Enrollments in the Provider Enrollment Chain Ownership System (PECOS). Shut Down All Provider Enrollment Functions in the Carrier Enrollment System (PENS). Create Import/Export Functionality Between the Viable Medicare System (VMS) and the Provider Enrollment Chain Ownership System (PECOS)	7/1/2003
AB-03-016	CR 2240 Question and Answer Document and Claims Processing Instructions for Processing Rejected Claims	2/7/2003
AB-03-018	Implementation of the Financial Limitation for Outpatient Rehabilitation Services	7/1/2003
A-03-009	Medical Nutrition Therapy (MNT) Services for Beneficiaries with Diabetes or Renal Disease - CORRECTION	4/1/2003
AB-03-017	Scheduled Release for April Updates to Software Programs and Pricing/Coding Files	See PM
AB-03-014	Single Drug Pricer (SDP)	2/14/2003
B-03-012	Use of the National Drug Code (NDC) for Drug Claims at the Durable Medical Equipment Regional Carriers (DMERCs)	7/1/2003
A-03-008	Clarification of 3-Day Payment Window vs. 1-Day Payment Window for Hospitals Excluded from Inpatient Prospective Payment System (IPPS)	7/1/2003
B-03-011	Correct Payment of January and February 2003 Physician Services	7/1/2003
B-03-009	Durable Medical Equipment Regional Carriers (DMERCs)-New Modifier Needed to Invoke Advanced Beneficiary Notice (ABN) Logic for Hard Copy and Electronic Claims	7/1/2003
AB-03-011	Identifying the Primary Payer Amounts to Send to the Medicare Secondary Payer Pay Module (MSPPAY) and the Shared Systems When There Are Multiple Primary Payers on Electronic and Hardcopy Claims	7/1/2003
B-03-008	Medical Review (MR) Progressive Corrective Action (PCA) Continuation of Work Begun In Compliance with Change Request (CR) 2433	See PM

B-03-007	Minimum Number of Pricing Files That Must Be Maintained Online for Medicare Physician Fee Schedule (MPFS) Services	7/1/2003
Policy Number	Description	Effective Date
AB-03-013	New Waived Tests - December 17, 2002	4/1/2003
A-03-007	Payment to Hospitals and Units Excluded from the Acute Inpatient Prospective Payment System (IPPS) for Direct Graduate Medical Education (DGME) and Nursing and Allied Health (N&AH) Education for Medicare+Choice (M+C) Enrollees	7/1/2003
B-03-010	Program Integrity Management Reporting (PIMR) System for Part B - Implementation of an Automated Edit Description Module	7/1/2003
AB-03-012	Remittance Advice Remark and Reason Code Update	4/1/2003
AB-03-010	Shared System Maintainer Hours for Resolution of Problems Detected During Health Insurance Portability and Accountability Act (HIPAA) Transaction Release Testing	7/1/2003
AB-03-015	Shared Systems Changes for Name Change from HCFA to CMS (MCS and CWF external changes only)	7/1/2003
A-03-006	Update the Medicare Secondary Payment Module (MSPPAY) to Apportion Prospective Payment System (PPS) Outlier Amounts to all Service Lines With Medicare Reimbursement That are PRICER Related and Potential Outlier Service Lines	7/1/2003