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Washington Report –January, 2009

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Economic Stimulus

Due to the size of the economic stimulus bill, officially known as the American Recovery and Reinvestment Act, a separate GR report and summary will be issued that deals exclusively with that legislation.

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Obama Administration Issues Memorandum suspending pending rulemaking

As one of his first official acts, President Obama notified all agencies that they were to cease work on all pending regulatory changes until the new

Administration has an opportunity to review the work. This was not unexpected and follows a tradition going back to the Reagan Administration. As a result of this announcement, no further work on any pending rule will take place in HHS or CMS until it has been reviewed by Obama Administration officials. This review can be waived in the case of an emergency or in order to comply with a statutory or judicial deadline.

It is not clear how long this review process will take. At a minimum, it is expected that it will take several months to complete the review. It should be noted that it will take several more weeks before the new CMS Administrator is in place, as well as those political appointees below the Administrator level. It is conceivable that the review of Medicare/Medicaid rules will not commence until those political appointees are in place.

During that time period, agencies that voluntarily extend the effective date should "immediately reopen the notice-and-comment period on that rule for 30 days".

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ICD 10/5010 Rule Issued

Just days before leaving office, Bush administration officials published final rules mandating use of the ICD-10 code classification system as well as updating of the transaction code set standards (referred to as the 5010 standards). As of the publication date of the Washington Report, no action had been taken to delay or change the ICD-10/5010 rule.

In issuing the new requirements, the Department of Health and Human Services (HHS) stated that these new rules, “will facilitate the United States’ ongoing transition to an electronic health care environment through adoption of a new generation of diagnosis and procedure codes and updated standards for electronic health care and pharmacy transactions.”

Current U.S. standards use the ICD-9-CM code sets to report health care diagnoses and procedures and for payment purposes. The final rule mandates use of ICD-10 beginning **October 1, 2014.**

The second final rule adopts an updated X12 standard, Version 5010, for electronic health care transactions. Version 5010 includes updated standards for claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions. Version 5010 also accommodates the use of the ICD-10 code sets, which are not supported by the current X12 standard known as version 4010/4010A1. The 5010 final rule mandates use of the new transaction code sets beginning **January 1, 2012**.

The original proposed rule published in late August, 2008, recommended a start date for the 5010 standards of 2010 and an implementation date for ICD-10 of 2011. The new dates are consistent with the recommendations of the Healthcare Billing and Management Association and other organizations.

In releasing the final regulations, Bush Administration HHS Secretary Mike Leavitt said "These regulations will move the nation toward a more efficient, quality-focused health care system by helping accelerate the widespread adoption of health information technology." "The greatly expanded ICD-10 code sets will fully support quality reporting, pay-for-performance, bio-surveillance, and other critical activities. The updated X12 transaction standards, Version 5010, provide the framework needed to support the ICD-10 codes."

The ICD-10 rule titled "HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD–10–CM and ICD–10–PCS" is available at: http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf .

The updated X12 transaction standards, version 5010, rule titled "Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards" is available at: http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf .

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Now You See Him, Now you Don't

Shortly after his election President Obama announced his selection of Tom Daschle as his nominee to be Secretary of Health and Human Services. In addition to the formal position as HHS Secretary, Daschle would also serve as the White House Health Czar, overseeing all health policy for the Obama Administration. As a former United States Senator from South Dakota, as well as Senate Majority Leader, Daschle was expected to sail through the confirmation process. But a funny thing happened on his to the Humphrey Building…

After an initial hearing before the Senate Health Education Labor and Pensions (HELP) Committee (one of two Senate Committees with jurisdiction over this cabinet position) there was no action on the Daschle nomination. Normally, Cabinet appointees with multiple committee jurisdictions are schedule in rapid sequence. In this case, the HELP Committee nomination hearing should have been followed immediately by a Senate Finance Committee hearing. When no Finance Committee confirmation hearing was scheduled, eyebrows were raised.

As it turns out, the Finance Committee staff had uncovered a bit of a tax problem involving Senator Daschle's tax returns. Despite what some considered a "glitche", it turned out to be a serious problem for the former Senator. After a closed door meeting with Senators from both parties, which some later described as both frank and sobering, the Senator decided to withdraw his name from consideration.

Rumors abound as to who might be President Obama's next choice to head the Department of Health and Human Services. Whoever it may be, he or she will be charged with leading an agency with a budget that is larger than the total budgets of most countries. In addition, the next Secretary of HHS is expected to be the President's point person on both Medicare reform and healthcare

reform.

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Change in Washington

January kicked off with the swearing in of the new Congress. As a result of the November elections, the majorities enjoyed by the Democrats in the House and Senate have increased making Republicans less influential in national politics than they have been since the end of the Carter Administration.

We still don't know the full extent of the Democrat victories as the Minnesota Senate race continues in the courts over the counting of all the ballots. On election night, incumbent Republican Senator Norm Coleman led Democrat Al Franken by a slim 200 votes. After the recount, Franken led by approximately 200 votes. It is not clear when that race will be decided.

By virtue of their expanded majorities, Democrats took the opportunity to expand their majorities on Committee reflecting their increased political power. Again, these new, bigger, majorities will make it harder for Republicans to have influence over policy.

But Republicans did hold onto one power – the filibuster. Under Senate rules, most legislation can be blocked via a filibuster (unending debate) unless 60 Senators vote to end debate. Should Franken prevail after the conclusion of the Minnesota recount, the Democrat majority in the Senate will stand at 57 Democrats, 2 Independents (who caucus with the Democrats) and 41 Republicans.

In the House, the size of a majority is, in some ways, meaningless. The rules of the House are such that the majority rules. A two vote majority can be just as powerful in the House as a 50 vote majority. The current breakdown in the House is 256 Democrats to 178 Republicans, with 1 vacancy.

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More Change in Washington, DC

Not long after the 111th Congress (each Congress is two years) was sworn in, preparations for the inauguration of Barrack Obama as the 44th President of the United States began in earnest.

The inauguration of a new President is always a spectacular occasion not only in Washington, but in communities all around America. But being here, watching the build-up to the peaceful transition of government is very poignant.

For those of us who live and work in the Washington, DC area, however, the inauguration of a new President also means street closings, even worse traffic than usual, and extra long waits at security check points.

The inauguration of Barrack Obama as our nation's 44th President was a particularly historic occasion. Regardless of whether you voted for him or not, you could not help but appreciate the social and political significance of his election.

The day after the inauguration is not unlike the morning after a late night binge when your head is pounding, your mouth is dry but you have that important meeting you just have to be sharp for. In other words, the work begins and in the case of a new President, it begins in earnest.

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S-CHIP Reauthorization First Health Bill out of the Chute

The 111th Congress wanted to act swiftly to pass legislation reauthorizing the State Children's Health Insurance Program (S-CHIP). As you may recall, the Democrat controlled 110th Congress sought to expand and reauthorize the S-CHIP program only to have that legislation vetoed by President Bush. Working largely from the vetoed bill, the new Congress moved swiftly to enact H.R. 2, a bill to "extend and improve the Children's Health Insurance Program".

Because the House and Senate passed virtually identical versions of the bill, it was unnecessary for the convening of a Conference Committee to resolve the differences. Instead, the House accepted the changes the Senate made in the bill and on February 3rd, President Obama signed one of his first major pieces of legislation into law. So H.R. 2, will forever more be known as Public Law 111-3.

During a public bill signing ceremony, President Obama said, "we fulfill one of the highest responsibilities that we have: to ensure the health and well-being of our nation's children. It's a responsibility that's only grown more urgent as our economic crisis deepens, with health care costs that have exploded, and millions of working families are unable to afford health insurance."

The new legislation not only continues the program, which would have expired at the end of March, 2009 had Congress and the President not acted, but it expands eligibility so that more than 10 Million children will now qualify for this state run health insurance program.

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CMS Issues Three National Coverage Determinations on Preventable Surgical Errors

The Centers for Medicare & Medicaid Services (CMS) has announced three national coverage determinations (NCDs) to establish uniform national policies that the agency believes will help prevent Medicare from paying for certain serious, preventable errors in medical care. These errors, referred to as "never events," are identified in the National Quality Forum's (NQF) list of Serious Reportable Events:

- Wrong surgical or other invasive procedures performed on a patient;
- Surgical or other invasive procedures performed on the wrong body part; and
- Surgical or other invasive procedures performed on the wrong patient.

In addition, consistent with current policy for non-covered services, Medicare does not cover any services related to these non-covered services.

CMS determined that the NCD process was appropriate to address coverage for the three types of surgical errors cited above. These NCDs may affect payment to hospitals, physicians, and any other health care providers and suppliers involved in the erroneous surgeries.

For discharges occurring on or after Oct. 1, 2008, Medicare will no longer pay a hospital at a higher rate for an inpatient hospital stay if the sole reason for the enhanced payment is one of the selected HACs, and the condition was acquired during the hospital stay. CMS is exploring the feasibility of adapting this policy to its other payment systems.

These NCDs are effective immediately, however; implementation instructions for processing such claims will occur at a later date. To view the NCDs, visit:

Wrong body part:
www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=222
Wrong patient:
www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=221
Wrong surgery performed on a patient:
www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=223

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CMS Seeks Public Comment on Extending the Effective Date of the DMEPOS Competitive Bidding

The Centers for Medicare & Medicaid Services (CMS) issued a notice seeking comment on a contemplated delay of 60 days in the effective date of the interim final rule entitled "Medicare Program; Changes to the Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) by Certain Provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)."

The interim final rule, published in the Federal Register on January 16, 2009, implements certain MIPPA provisions that (1) delay implementation of Round I of the competitive bidding program, (2) require CMS to conduct a second Round 1 competition in 2009, and (3) mandate certain changes for the Round 1 rebid and subsequent rounds of the program, including the development of a process for providing feedback to suppliers regarding missing financial documentation and the requirement that contractors disclose to CMS information regarding subcontracting relationships.

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Implementing Best Patient Care Practices

The Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing on Implementing Best Patient Care Practices. Senator Barbara Mikulski (D-MD) acted as chairman for the hearing in Senator Edward Kennedy's absence.

The hearing opened with Senator Mikulski citing her goals for the future of health care. She discussed a patient-centered health care system focusing on prevention, intervention and care management. She believes that the development of health information technology (HIT) will greatly advance our system; however, she stressed it is necessary to incorporate and improve the care provided by people.

Dr. Peter J. Pronovost, Medical Director of the Center for Innovations in Quality Patient Care at Johns Hopkins University began the hearing with a story about an eighteen-month old girl from Johns Hopkins Hospital who died as a result of preventable mistakes. He explained that it has been four years since her death and the mistakes that led to her death, still occur. He spoke passionately about eliminating the gap between what scientists and doctors learn in labs and what discoveries actually reach patients.

Dr. Steven D. Pearson, President, Institute for Clinical and Economic Review (ICER), Boston, MA discussed the relationship between "comparative effectiveness" and "best practices." He explained that comparative effectiveness research establishes which treatments are best for which kinds of patients and best practices research determines how to safely, effectively and efficiently deliver those treatments to patients.

Dr. Donald R. Fischer Chief Medical Officer for Highmark Blue Cross Blue Shield discussed his company's programs to improve quality and affordability by facilitating the adoption of best patient care practices for hospitals, primary care physicians and members. He mentioned the use of pay-for-performance (P4P) programs, QualityBLUE, and Lifestyle Returns. Dr. Fischer emphasized in order to improve quality, you need four major components to your program:

Quality indicators
Financial incentives for Physicians
Coaching and guidance
Incentives to patients

Dr. Fischer explained that coaching is provided by medical management consultants and directors and pharmaceutical staff. They explain real time data and indicators in order to adjust hospitals and staff to systematic approaches. Dr. Fischer added that at first, doctors were resistant; however, the consultants and directors developed relationships and established common goals that resulted in success.

Some of the ideas and concepts expressed during this hearing are expected to receive greater attention and consideration when Congress begins debating healthcare reform later this year.

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Having problems with your Carrier or MAC

The Healthcare Billing and Management Association receives periodic inquiries or complaints from members relative to problems they are encountering with Medicare contractors It might be a problem associated with the transition from Medicare Administrative Contractors (MACs) or simply an on-going enrollment problem with an existing contractor.

When HBMA members encounter problems with Medicare contractors that are not getting resolved in a timely fashion, they are encouraged to contact the HBMA national office. Depending upon the nature of the problem, we may be able to provide some guidance on getting a problem resolved.

Why do we want to know even if we can't help? HBMA is often asked by CMS about problems from the field. Even when we are unable to help with an immediate problem, by knowing about problems, we may be able to alert CMS to issues or systemic problems that have not yet come to the Central Office's attention.

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RACs are BAAACK

In October 2008, CMS announced the award of contracts to four national recovery audit contractors (RACs). As has previously been reported, those contracts were protested and a stop work order was put in place. Consequently, the implementation of the national RAC program was put on hold until the protests could be resolved. The protests have now been resolved and the RAC program is moving forward.

CMS will implement a permanent and national RAC program by January 1, 2010. The national RAC program is the outgrowth of a demonstration program that used RACs to identify Medicare over-payments and underpayments to health care providers and suppliers in six states.

The Recovery Audit Contractors and the states they will cover are:

Diversified Collection Services (DCS)

Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York.

CGI Technologies and Solutions (CGI)

Michigan, Indiana and Minnesota.

Connolly Consulting Associates (CCA)

South Carolina, Florida, Colorado and New Mexico.

HealthDataInsights (HDI)

Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.

As part of the settlement CMS negotiated with the companies that protested the awared, the four RACs will subcontract some of their work. PRG-Schultz, Inc. will serve as a subcontractor to HDI, DCS and CGI. Viant Payment Systems, Inc. will serve as a subcontractor to Connolly Consulting. Each subcontractor has negotiated different responsibilities in each region, including some claims review.

Over the next several months, CMS will begin contacting associations and providers to discuss provider outreach sessions involving the RACs. Providers will not begin receiving correspondence from a RAC until the RAC and CMS have completed the provider outreach.

For additional information on the RAC program, please see the CMS website at: http://www.cms.hhs.gov/RAC/

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Medicare Physician Fee Schedule - Carrier Specific Pricing Files

The Centers for Medicare & Medicaid Services (CMS) has condensed all 56 Physician Fee Schedule (PFS) carrier specific pricing files into one zip file. This file is found in the list on the CMS web page at

http://www.cms.hhs.gov/PhysicianFeeSched/PFSCSF/list.asp.

It is labeled as "All States" in the State field, and "2009" in the Calendar Year field. Because the list is ordered by State name, "All States" appears after the Alaska files. If you sort by most recent Calendar Year, the file will appear at the top of the list.

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Congress looking at HIT and Privacy Issues

On Tuesday, January 27, 2009, the Senate Judiciary Committee held a hearing concerning Health IT and the protection of privacy

The witnesses who testified at the hearing included: James Hester, Jr., Director of Health Care Reform Commission in the Vermont State Legislature; Adrienne Hahn, Senior Attorney and Program Manager for Health Policy Consumers Union; Deven McGraw, Director of Health Privacy Project for the Center for

Democracy and Technology; Michael Stokes, Principal Lead Program Manager for Health Vault, Microsoft Corporation; John Houston, Vice President of Information Security and Privacy for the University of Pittsburgh Medical Center; and David Merritt, Project Director for the Center for Health Transformation and the Gingrich Group.

The hearing was chaired by Senator Sheldon Whitehouse (D-RI). In his opening statement Senator Whitehouse mentioned that the best way to solve the healthcare cost problem is through Health Information Technology (HIT). He argued that an investment in quality and payment reform were important principles that must be addressed in solving this issue. Furthermore, he asserted that "privacy is the Achilles Heel of Electronic Health Records (EHR)."

Senator Orrin Hatch (R-UT) started his remarks by noting that HIT saves time, cost, and lives. He called for the use of HIT to spread clinical research and to reduce paperwork claims. Lastly, he noted that there is no reason why EHRs cannot be accessed securely, and that a nationwide HIT infrastructure is needed with good privacy and security regulations.

Senator Amy Klobuchar (D-MN) called for the development of rules and regulations to boost consumer confidence in ensuring privacy and security, mentioning patient consent and the private right of action.

Michael Stokes (Microsoft Corporation) outlined three principles concerning HIT and privacy.

1. Transparency he noted is essential for data collection concerning use and disclosure.
2. The need for control, so that health data can be managed and patients can decide when and what information is disclosed.
3. Security. There should not be limits to access of EHR for researchers who can provide new breakthroughs.

Senator Whitehouse (D-RI) asked all witnesses about the concept of creating a Federal health board to protect privacy.

All of the witnesses universally supported the creation of a federal board.

The Economic Stimulus bill has an extensive section on EHR/HIT standards. These will be reviewed and outlined in a separate document for the HBMA membership.

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Healthcare Reform in '09?

Senate Finance Chairman Max Baucus (D-MT) recently told a group of health policy experts that an overhaul of the nation's healthcare system needs to move

this year. This announcement represents a shift from previous statements by Baucus that work on comprehensive healthcare legislation would slip to next year.

In response to questions, Baucus said, “The longer it takes, the more likely it is that the agenda becomes crowded with other priorities.” His comments came before former Senate Majority Leader Tom Daschle withdrew as President Obama's nominee for HHS secretary. The withdrawal of Daschle could complicate Baucus’ plans to try to move comprehensive healthcare reform legislation this year.

Prior to taking on comprehensive healthcare reform, the Congress is expected to address Medicare reform issues. Unless Congress intervenes to prevent it, a cut in physician fee schedule payments of approximately 20% is schedule to take effect on January 1, 2010.

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CMS Transmittals

The following transmittals were issued by CMS in January, 2009.

Transmittal No.	Subject	Effective Date
R23COM	Implementation of New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries	N/A
R435OTN	VMS Modifications to Implement the Common Electronic Data Interchange (CEDI) System, Final Implementation	04/06/2009
R438OTN	New "";WW""; Code to Identify a New Source for Topotecan	07/06/2009
R147FM	Chapter 7-Internal Control Requirements Update	03/09/2009
R440OTN	Facet Joints	03/09/2009
R439OTN	Influenza Pandemic Emergency-Additional Guidance Concerning the Medicare Prescription Drug Program (Part D) and Medicare Advantage (Part C)	03/09/2009
R436OTN	Re-design of FISS Edits for Hemophilia Clotting Factors on Inpatient Claims	07/06/2009
R437OTN	Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Coordination of Benefits (COB) Requirements---Multi-Carrier System	10/05/2009

	(MCS)	
R434OTN	Correction to Home Health Prospective Payment System (HH PPS) Episode Sequence Edits	07/06/2009
R1672CP	Payment for Co-surgeons in a Method II Critical Access Hospital (CAH	07/06/2009
R1676CP	Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals	05/04/2009
R1675CP	Standard System Change to Allow Claims Processing Contractors Flexibility with 9-Digit ZIP Code	07/06/2009
R1673CP	Correction to the Common Working File (CWF) for Late Recertifications	07/06/2009
R433OTN	FISS, CWF and NCH System Requirements for All Outpatient 837 I Claims Related to Rendering Physicians/Practitioners	07/06/2009
R1674CP	Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update	04/06/2009
R1670CP	Claim Status Category Code and Claim Status Code Update	04/06/2009
R430OTN	Long Term Care Hospital (LTCH) Special Project	02/17/2009
R101BP	January 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)	01/05/2009
R146FM	Notice of New Interest Rate for Medicare Overpayments and underpayments 2nd Notification for FY 2009	01/23/2009
R429OTN	Update to Change Request 5927--Shared Systems Active and Non-Active Edits/Reason Codes and Audit Trail Reporting	04/06/2009
R431OTN	Jurisdiction 3 A/B MAC Merge of the Part B Arizona, Montana and Utah CICS Production and User Acceptance Testing Regions	04/06/2009
R1671CP	Clarification of Requirements for New and Material Evidence as Good Cause for Reopening	02/16/2009

R1669CP	January 2009 Update of the Ambulatory Surgical Center (ASC) Payment System	01/05/2009
R64MSP	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers""; Compensation Medicare Set-aside Arrangements (WCMSAs), to Stop Conditional Payments	N/A
R1665CP	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers""; Compensation Medicare Set-aside Arrangements (WCMSAs), to Stop Conditional Payments	N/A
R1664CP	January 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.0	01/05/2009
R1666CP	Instructions for Fiscal Intermediary Standard System (FISS), Multi-Carrier System (MCS) and Healthcare Integrated General Ledger Accounting System (HIGLAS) Changes	01/05/2009
R145FM	Recovery Audit Contractors (RACs)	03/13/2009
R1667CP	Instructions for Fiscal Intermediary Standard System (FISS), Multi-Carrier System (MCS) and Healthcare Integrated General Ledger Accounting System (HIGLAS) Changes	10/06/2008
R428OTN	Influenza Pandemic Emergency Preparedness Additional Guidance Concerning Tentative and Final Settlements, Periodic Interim Payments (PIP) and Pass Through Payments, Medicare Secondary Payer (MSP), Accelerated Payments, Repayments and Financial Management	02/13/2009
R1663CP	Correction to Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management	02/09/2009
R282PI	Zone Program Integrity Contractor (ZPIC) Updates	01/26/2009
R1662CP	Home Health Prospective Payment System Rate Update for Calendar Year 2009	01/05/2009
R1661CP	Emergency Update to the 2009 Medicare Physician Fee Schedule Database (MPFSDB)	01/05/2009

SE0902	Important Information for Providers Serving Medicare Beneficiaries Enrolled in Private Fee-for-Service Plans	N/A

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