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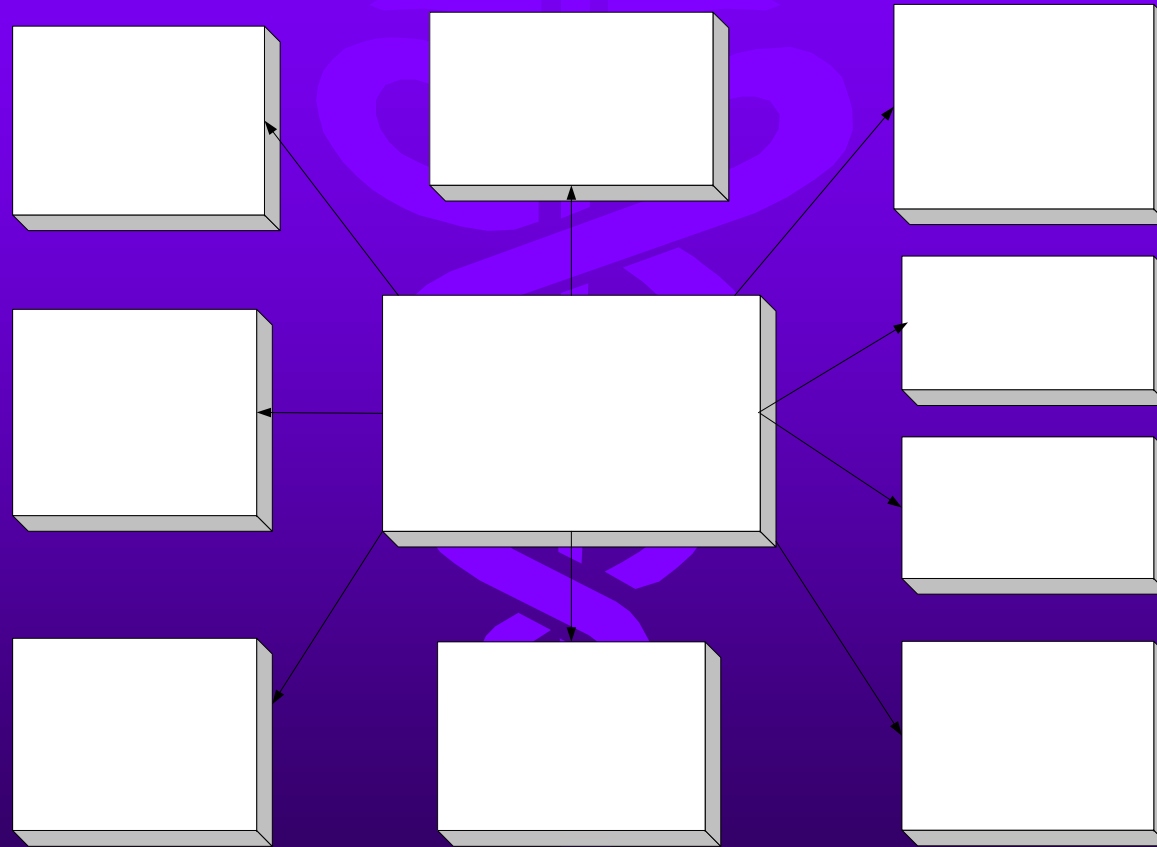
**MISSOURI CHAPTER  
SCIENTIFIC MEETING  
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# THE CHANGING MEDICARE CLIMATE

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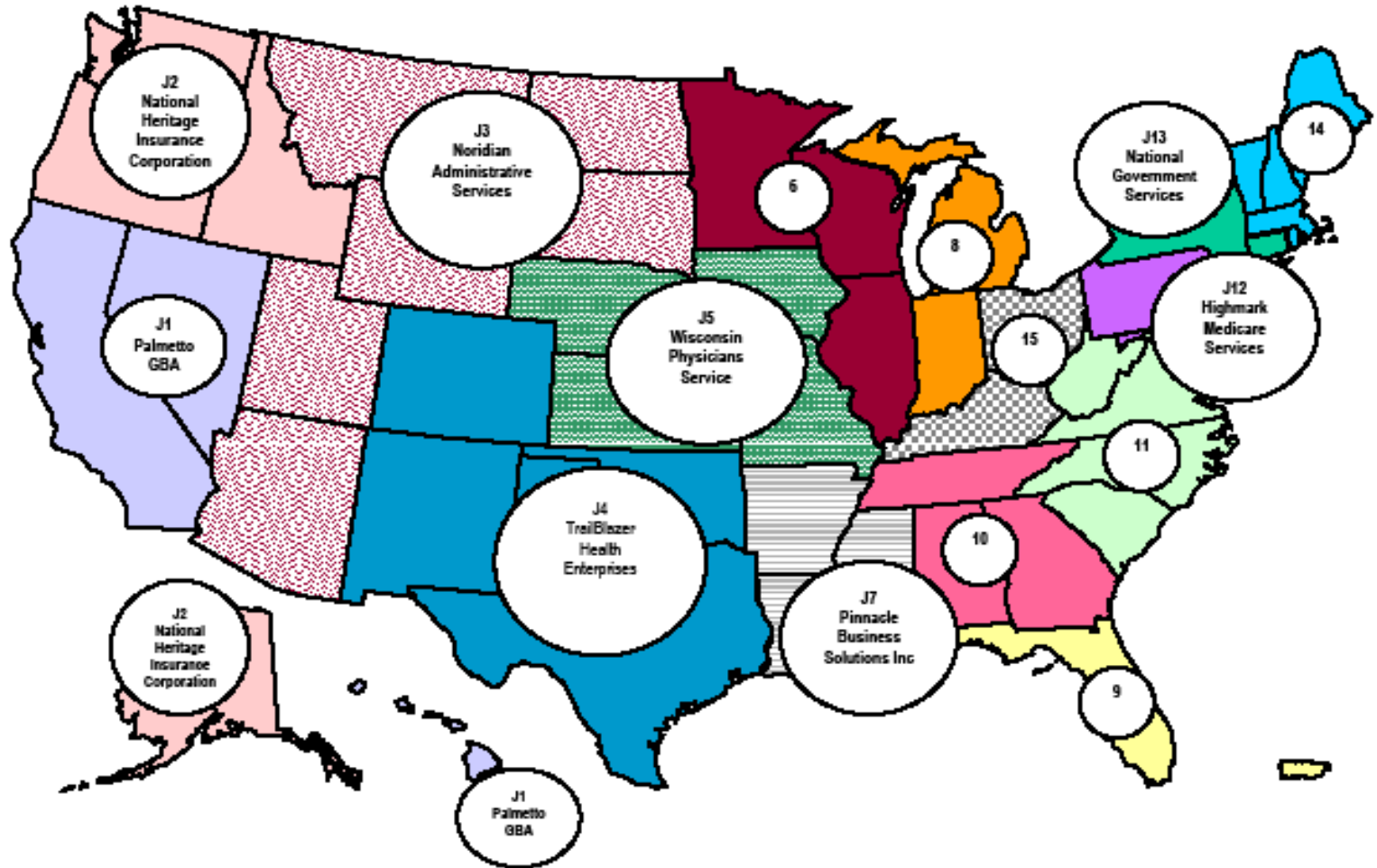
# Administrative Functional Environment



# Medicare Administrative Contractor (MAC)

- In the future FFS environment, MACs will assume work currently performed by FIs and carriers, and serve as providers' primary point-of-contact for the receipt, processing, and payment of claims.

# A/B MAC Jurisdictions Map



# Qualified Independent Contractors (QICs)

The QICs are responsible for conducting the second level of appeals

(reconsiderations of initial determinations of Medicare claims).

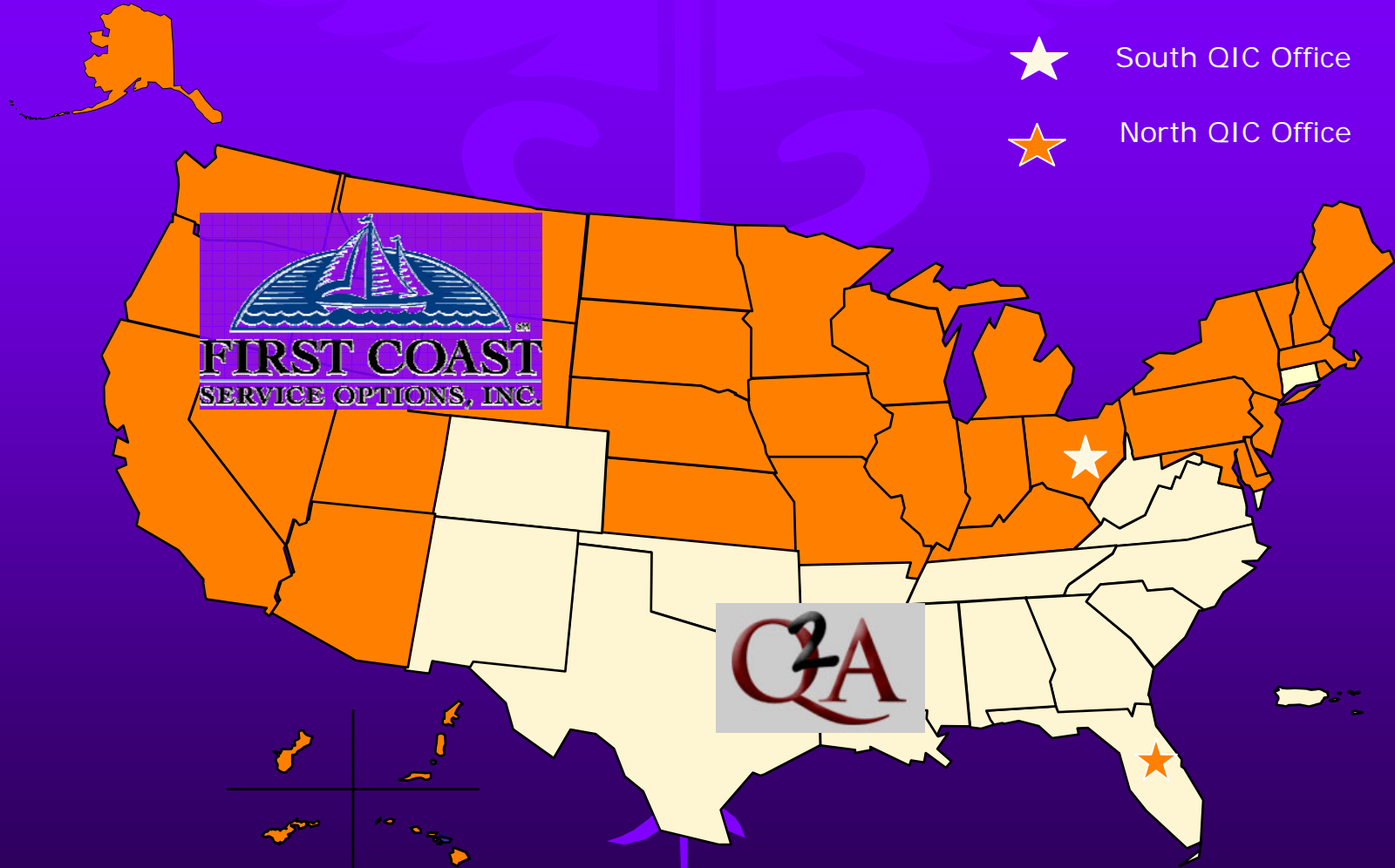
The MAC is responsible for handling the first level of appeals (Redeterminations).

The QIC task order established three jurisdictions (north, south, and Durable Medical).

## *Minor Errors and Omissions*

- Providers should be aware that there is no need to appeal a claim if the provider has made a minor error or omission in filing the claim, which, in turn, caused the claim to be denied. In the case where a minor error or omission is involved, the provider can request that the Medicare contractor reopen the claim so the error or omission can be corrected, rather than having to go through the appeals process.

# Part B QICs Jurisdictions



Note: The CT reconsideration workload will be processed as part of the South jurisdiction.

# Recovery Audit Contractors (RACs)

- The RACs, are responsible for identifying improper Medicare payments that may have been made to healthcare providers and that were not detected through existing program integrity efforts.

# **CMS PROGRAM IDENTIFIES \$371.5 MILLION IN IMPROPER MEDICARE PAYMENTS IN THREE STATES**

- The Centers for Medicare & Medicaid Services (CMS) today announced that \$371.5 million in improper Medicare payments has been collected from or repaid to health care providers and suppliers as part of a demonstration program using recovery audit contractors (RACs) in California, Florida and New York in 2007. Nearly \$440 million has been collected since the program began in 2005.

# MEDICARE'S FINANCIAL STATUS 2008

Medicare Trustees Report to Congress:

- In their annual report, the Medicare Trustees today announced that both the Medicare Hospital Trust Fund and the Supplementary Medical Insurance Trust Fund expenditures are growing faster than the rest of the economy. The Trustees report expenditures were \$432 billion in 2007, or 3.2 percent of gross domestic product (GDP), and are projected to increase to nearly 11 percent of GDP in 75 years.

# FINANCIAL STATUS, cont.

- The Trustees report that Medicare's Hospital Insurance (HI) Trust Fund will become insolvent earlier in 2019 than reported last year.
- This year the HI Trust Fund will spend more than its income, and from 2009 through 2017, about \$342 billion will need to be transferred from the Federal treasury to cover beneficiaries' hospital insurance costs.

# FINANCIAL STATUS, cont.

- The Supplementary Medical Insurance (SMI) Trust Fund is automatically in financial balance because beneficiary premiums and general revenue financing are reset each year to match the expected costs of the program for the following year. However, Part B benefit payments have increased by an average of 9.6 percent for each of the past five years and that continued growth remains a concern.

# Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

- **Physician Payment**  
Increased by \$6.4 billion through 2013
- Prevents a reduction and freezes 2008 fee schedule payment rates at current levels. Increases 2009 fee schedule by 1.1%.

## MIPPA cont.

- E-prescribing coupled with PQRI can raise payments by 4% in 2009
- Passage of the recent Medicare Improvements for Patients and Providers Act (MIPPA) includes incentives for you to adopt and utilize electronic prescribing - known as e-prescribing - starting Jan. 1.
- Eventually your payments will be reduced if you don't e-prescribe.

## MIPPA cont.

- CMS officials say the new incentive program for e-prescribing will be similar to the Physician Quality Reporting Initiative (PQRI) in that it will improve care and pay more for quality care. The bonus breakdown for services using e-prescribing will be:
  - · 2% in 2009 and 2010,
  - · 1% in 2011 and 2012, and
  - · 0.5% in 2013.
- **NOTE:** The PQRI includes a 2% incentive bonus, too

## MIPPA cont.

- **E-prescribing implementation will include costs**
- The bonuses that will accompany use of e-prescribing will not come without costs if you haven't already implemented e-prescribing. An e-prescribing system can cost you about \$3,000 plus the expense of training and on-going maintenance.
- It's difficult to tell whether incentives will cover your costs, but based on payments for the 2007 PQRI program it could be a couple hundred to a couple thousand dollars.

# Erythropoiesis Stimulating Agents (ESAs)

- Background: Results of studies reported in 2006 and early 2007 showed adverse effects in patients being treated with ESAs for cancer patients receiving radiotherapy, cancer patients not receiving chemotherapy, patients undergoing surgery and patients with chronic renal failure. Patients with certain types of cancer also had decreased survival compared to placebo.

## ESAs (cont.)

- Results:
- Black Box Warning added to label for all ESAs.
- Medicare contractors deleted coverage for ESAs in patients with a diagnosis of anemia with non-myeloid malignancies.
- CMS issued an Decision Memo eliminating coverage for anemia of cancer and related neoplastic conditions.

## ESAs (cont.)

- The effective date of the Decision Memo was 07/30/2007.
- Very controversial decision.
- Required all Medicare contractors to revise their LCDs on ESAs.
- Protests by a variety of groups including ASCO and ASH.
- Immediate calls for NCD reconsideration including congress.

## ESAs (cont.)

- Does not allow payment for ESAs in:
- Any anemia in cancer patients due to folate, B-12, or iron deficiency, hemolysis, bleeding, bone marrow fibrosis.
- Anemia associated with treatment of AML, CML or erythroid cancers.
- Anemia of cancer not related to cancer treatment.
- Any anemia associated with radiotherapy.

# MEDICARE PREVENTIVE SERVICES

- Initial Preventive Physical Examination (IPPE)

## IPPE (cont.)

- Also called “Welcome to Medicare Exam”
- One time benefit
- Must be completed within 6 months of eligibility
- Performed by a physician or qualified non-physician practitioner

# Breast Cancer Screening

- All women with Medicare age 40 and older can get a screening mammogram every 12 months. Medicare also pays for one baseline mammogram for women with Medicare between ages 35 and 39.

# Cervical and Vaginal Cancer Screening

- A Pap test and pelvic exam are covered by Medicare once every 24 months. However, if you are of childbearing age and have had an abnormal Pap test within the past 36 months, or if you are at high risk for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic exam every 12 months.

# Colon Cancer Screening

- Fecal Occult Blood Test - Once every 12 months
- Flexible Sigmoidoscopy - Once every 48 months
- Screening Colonoscopy - Once every 24 months (if you're at high risk); once every 10 years, but not within 48 months of a screening sigmoidoscopy (if you're not at high risk)
- Barium Enema - Your doctor can decide to use this test instead of a flexible sigmoidoscopy or colonoscopy. This test is covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.

# Prostate Cancer Screening

- Digital Rectal Examination - Once every 12 months
- Prostate Specific Antigen (PSA) Test - Once every 12 months

# HHS Proposes Adoption of ICD-10 Code Sets and Updated Electronic Transaction Standards

- The Department of Health and Human Services (HHS) announced a long-awaited proposed regulation that would replace the ICD-9-CM code sets now used to report health care diagnoses and procedures with greatly expanded ICD-10 code sets, effective October 1, 2011

## ICD-10 cont.

- In a separate proposed regulation, HHS has proposed adopting the updated X12 standard, Version 5010, and the National Council for Prescription Drug Programs standard, Version D.0, for electronic transactions, such as health care claims. Version 5010 is essential to use of the ICD-10 codes.

## ICD-10 cont.

- Developed almost 30 years ago, ICD-9 is now widely viewed as outdated because of its limited ability to accommodate new procedures and diagnoses. ICD-9 contains only 17,000 codes and is expected to start running out of available codes next year. By contrast, the ICD-10 code sets contain more than 155,000 codes and accommodate a host of new diagnoses and procedures

# Thank You

- Questions?

