Providers have the opportunity to participate with Medicare once annually. This period called “Open Enrollment” is usually from mid-November to the end of the calendar year. Providers who may have declined to participate with Medicare for the 2010 calendar year due to the anticipated deep cuts in the physician Medicare fee schedule now have a special opportunity to jump on board between now and July 16, 2010.

Here is the announcement:

Dear Medicare Part A and Part B Providers,

Opportunity for Nonparticipating Physicians/Practitioners to Become Participating

In consideration of the recent enactment of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, which established a 2.2 percent update to the Medicare Physician Fee Schedule (MPFS), the Centers for Medicare & Medicare Services (CMS) is offering physicians and other practitioners, whose current participation status is non-participating, the opportunity to become participating (PAR). This opportunity is being offered only to those physicians/practitioners whose current PAR status is non-participating. This opportunity is available through July 16, 2010.
Non-participating physicians/practitioners who would like to become a participating physician/practitioner should download and complete the Medicare Participating Physician or Supplier Agreement (Form CMS-460). The form can be obtained by using the following CMS web site link: http://www.cms.gov/cmsforms/downloads/cms460.pdf.

Any new CMS-460 form received during this limited enrollment period will be retroactive for claims with dates of service of January 1, 2010, and later. However, the change in participation status will only apply to new MPFS claims submitted after your new status as a participating physician/practitioner is processed. Claims previously submitted and processed will not be adjusted for only a change in participation status.

Medicare claims administration contractors (Medicare Administrative Contractors and carriers) will accept and process requests to become a participating physician/practitioner that are submitted on the CMS-460 form and are post-marked on or before July 16, 2010.

13 Ways to Energize New Staff or Re-energize the Long Timers

Image by The Library of Virginia via Flickr
Sometimes a job just gets a little old, and even the best employees need a little something to get them re-engaged and excited again. Try one of the ideas below at your practice and let me know in the comments the ways you keep your staff energized and engaged!

1. **Provide a career track and offer multiple levels of learning jobs.** For instance, break the receptionist job into steps (see below) and set time lines for attaining those goals. You may want several steps to be accomplished at 90-days, more at 6-months, and more at 12-months. There may be monetary awards, honor awards, or qualifications for other acknowledgements.

   - Pre-registering patients by phone – demographics
   - Making appointments & mini-register for new patients
   - Registering patients face-to-face – demographics
   - Understanding insurance plans and registering their insurance
   - Taking photo ID or taking photos and explaining the Red Flags Rule
   - Collecting co-pays
   - Answering basic patient questions
   - Answering advanced patient questions
   - Reviewing the financial policy with patients
   - Reviewing the Privacy Policy with patients.

2. **Offer certifications and credentials** – support staff emotionally, time-wise and financially so they can attend face-to-face or online courses.

3. **Offer specific responsibilities** and the title of lead person for that responsibility – don’t assume you know what staff are or are not capable of – they might surprise you!

4. **Meet every 6 months or every quarter to set goals.** A job can be a drag if there’s nothing new to learn or to
accomplish.

5. **Set up process improvement teams** to work on problems that everyone complains about – give them the responsibility to come up with solutions and try them out.

6. **Involve them in social media marketing of the practice.** Make sure they understand your social media plan (you do have a plan, don’t you?), give them guidelines to work within and let them work on your website, your blog, and your Facebook page.

7. **Install a wiki** (many are free) and have them work on loading all the practice knowledge into the wiki. Have different staff responsible for different parts of the wiki and set goals for adding all the information that runs your practice every day.

8. **“Walk a Mile in My Shoes”** – this is also great for getting the clinical and administrative staff to understand each other better. Have the staff shadow each other and take turns seeing parts of the practice they don’t know much about. I recently participated in this at my hospital and shadowed a nurse (and asked a million questions) for about an hour. It was wonderful! I felt better equipped to work with my hospitalist service after having been on a patient floor for just a short time.

9. If you are a practice that receives referrals from others, have staff responsible for regularly **touching base with staff from referring practices** and asking how service can be improved. Teach staff about relationship building and remember that it’s the staff that often choose where the patient is referred to instead of the provider.

10. Have staff take turns **going with you to meetings, seminars and local events** where you represent the practice and introduce them to everyone.
11. **Forward listserv discussions to employees** and have them monitor the discussions and bring things to you that they want to know more about.

12. Encourage employees to **become the practice expert** in a payer, an employer, a referrer, a process or a protocol and help them learn about their topic by sending them information from the web or your professional organizations.

13. Have the staff **put together an internal or external newsletter** and help them with concepts of internal and external marketing.

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**Diagnosis-Related Groups (DRGs)**

DRGs may not be familiar to many practice administrators as they are a payment method for hospitals. Applied to all U.S. hospitals as a Medicare reimbursement method in 1983, DRGs are groups of hospital services clustered around diagnoses.

The theory of DRGs is that this reimbursement system would require hospital administrators to alter the behavior of the physicians and surgeons comprising their medical staffs. (Are you thinking what I’m thinking about physician behavior?)

A defining moment in healthcare reimbursement was MS-DRG Grouper version 26. It took effect October 1, 2008 with one main change: implementation of Hospital Acquired Conditions (HAC). Certain conditions are no longer considered complications if they were not present on admission (POA), which will cause reduced reimbursement from Medicare for
conditions apparently caused by the hospital.

MS-DRG Grouper version 27 (pdf here) took effect as of October 1, 2009 and predominant changes are related
to Influenza A virus subtype H1N1.

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Deja Vu All Over Again: The Medicare Fee Cut is Pushed Back to November 30, 2010

I don’t know about you but I am emotionally exhausted thinking about and worrying about the on-again off-again cuts in Medicare fees for physicians.

Here’s the scoop: late Thursday evening, June 24, 2010, the House of Representatives passed the ”Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (H.R. 3962)” which includes a delay in the 21+% fee cut. Because the same legislation was already passed by the Senate, it now goes to the President for his signature and it becomes law. It is anticipated that this will happen quickly and CMS will have the MACs start processing new claims with dates of service of June 1, 2010 and later at the 2009 fee schedule plus a 2.2% increase. The MACs will also have to reprocess the claims already paid for dates of service June 1, 2010 and later that were processed with 2010 fee schedule and that big fat cut.

Q: What should we be doing for the next 5 months and 6 days?
A: Have someone in your practice take a video of your providers introducing themselves, telling how many Medicare patients they have and how they can’t afford to see Medicare patients unless the SGR formula is replaced with something that works. The video doesn’t have to be slick – just real. Send it to your senators and representatives. Send it your local TV news. Post it on YouTube. Imagine hundreds of thousands of providers introducing themselves and talking about their patients. It would be powerful.

Dealing With the Media: What’s a Medical Manager to Do?

Most medical practice managers do not aspire to be television, radio or (heaven forbid) YouTube celebrities, but it does happen. Medical practices, hospitals, surgical centers, nursing homes and other medical entities are rich fodder for
the news these days. So how do you weather the request for a sound bite without putting your practice in jeopardy? Follow these simple rules and you’ll be an asset to your practice in no time.

1. **The media is your friend, treat them that way.**
   Encourage reporters and journalists to call you for updates on your practice (new doctor, new facility, enhanced website, patient appreciation, health fair activities, etc.) AND to comment on new stories.

2. **Remember that “No comment” translates in the media as “I’m hiding something.”** Some information, even if it is a repeat or a rehash, is better than “no comment.”

3. Have your physicians and other administration agree that there is **only one spokesperson** and that they will refer all requests from the media to you.

4. **If you are asked a question that you cannot or do not want to answer**, probably in relation to something negative about your practice, the format to follow is:
   - Tell them that you are not able to answer that question,
   - Tell them why you can’t tell them (I don’t have that information at this time OR I’ve not received the report on this yet OR this matter is still being reviewed/evaluated/investigated at this time),
   - Tell them what you can tell them, which might be ‘We do know...” OR “What is clear at this time...” OR “What we’ve been told...”

5. **If the media isn’t calling you for news, call them!**

6. **Nothing is off the record** and you can’t unring that bell. Once you’ve said it, it is out there.

Don’t forget that doctors and healthcare are in the spotlight constantly these days and that negative press is not good for your practice, or the industry at large. Protect your practice by being a confident, competent and knowledgeable
Diagnosis (ICD-9 and ICD-10)

Update: MLN (Medicare Learning Network) published this pdf on ICD-10 on June 22, 2010

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The diagnosis is the identification of a patient’s disease or medical condition and is currently (2010) described by a six place numeric identifier (5 digits and one decimal) called the International Classification of Diseases, Ninth Revision or the ICD-9 code. **On October 1, 2013, the United States will move to ICD-10.** The International version of ICD should not be confused with national Clinical Modifications of ICD that include frequently much more detail, and sometimes have separate sections for procedures, so the new US ICD-10 CM has more than 150,000 codes.

**The differences are:**

ICD-9 codes consist of 3-5 digits:
"¢ Chapters 1-7 are numeric
"¢ Supplemental chapters: the first digit is alpha (E or V) and the rest are numeric

ICD-10-CM codes consist of 3-7 alphanumeric characters:
"¢ Digit 1 is alpha
"¢ Digit 2 is numeric
"¢ Digits 3-7 are alpha or numeric

2009 totals, according to the U.S. Department of Health and Human Services:
ICD-9-CM: 17,000
Diagnosis: 13,000
Procedure: 4,000

ICD-10: 140,694
Diagnosis (ICD-10-CM): 68,105
Procedure (ICD-10-PCS): 72,589

Healthcare Information Management, Inc. states:

The ICD-10-CM is divided into an index. The first is the alphabetical list of terms and their corresponding code. The second is the Tabular List, a chronological list of codes divided into chapters that represent different conditions or body systems. There are also two parts to the Index “the Index to External Causes of Injury and the Index for Diseases and Injury. The Index and Tabular portions of the ICD-10-CM include the conventions and structural notes.

The Tabular List contains alphanumeric categories, subcategories, and codes. When a three character category has no more subdivisions, it is considered a code. Each level of subdivision after the category is a subcategory. The "code' is considered complete once there are no more subcategories. A code indicated to have a 7th character is considered incomplete without the missing character.

In order to be reportable, only a complete "code' can be used. Subcategories or diagnoses that are not complete cannot be used for reporting. When there is an unknown subcategory, the place holder X is allowable in either the 5th or 6th position. This placeholder allows for the future addition of characters, thereby accommodating expansion when needed. The notes in the Tabular List will indicate categories where a 7th character is required.

ICD-9 codes are arranged thusly:
• List of ICD-9 codes 001-139: Infectious and parasitic diseases
• List of ICD-9 codes 140-239: Neoplasms
• List of ICD-9 codes 240-279: Endocrine, nutritional and metabolic diseases, and immunity disorders
• List of ICD-9 codes 280-289: Diseases of the blood and blood-forming organs
• List of ICD-9 codes 290-319: Mental disorders
• List of ICD-9 codes 320-359: Diseases of the nervous system
• List of ICD-9 codes 360-389: Diseases of the sense organs
• List of ICD-9 codes 390-459: Diseases of the circulatory system
• List of ICD-9 codes 460-519: Diseases of the respiratory system
• List of ICD-9 codes 520-579: Diseases of the digestive system
• List of ICD-9 codes 580-629: Diseases of the genitourinary system
• List of ICD-9 codes 630-676: Complications of pregnancy, childbirth, and the puerperium
• List of ICD-9 codes 680-709: Diseases of the skin and subcutaneous tissue
• List of ICD-9 codes 710-739: Diseases of the musculoskeletal system and connective tissue
• List of ICD-9 codes 740-759: Congenital anomalies
• List of ICD-9 codes 760-779: Certain conditions originating in the perinatal period
• List of ICD-9 codes 780-799: Symptoms, signs, and ill-defined conditions
• List of ICD-9 codes 800-999: Injury and poisoning
• List of ICD-9 codes E and V codes: external causes of injury and supplemental classification

And, the ICD-10 is arranged like this:
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Blocks</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>A00-B99</td>
<td>Certain infectious and parasitic diseases</td>
</tr>
<tr>
<td>II</td>
<td>C00-D48</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>III</td>
<td>D50-D89</td>
<td>Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism</td>
</tr>
<tr>
<td>IV</td>
<td>E00-E90</td>
<td>Endocrine, nutritional and metabolic diseases</td>
</tr>
<tr>
<td>V</td>
<td>F00-F99</td>
<td>Mental and behavioural disorders</td>
</tr>
<tr>
<td>VI</td>
<td>G00-G99</td>
<td>Diseases of the nervous system</td>
</tr>
<tr>
<td>VII</td>
<td>H00-H59</td>
<td>Diseases of the eye and adnexa</td>
</tr>
<tr>
<td>VIII</td>
<td>H60-H95</td>
<td>Diseases of the ear and mastoid process</td>
</tr>
<tr>
<td>IX</td>
<td>I00-I99</td>
<td>Diseases of the circulatory system</td>
</tr>
<tr>
<td>X</td>
<td>J00-J99</td>
<td>Diseases of the respiratory system</td>
</tr>
<tr>
<td>XI</td>
<td>K00-K93</td>
<td>Diseases of the digestive system</td>
</tr>
<tr>
<td>XII</td>
<td>L00-L99</td>
<td>Diseases of the skin and subcutaneous tissue</td>
</tr>
<tr>
<td>XIII</td>
<td>M00-M99</td>
<td>Diseases of the musculoskeletal system and connective tissue</td>
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</tr>
<tr>
<td>XIV</td>
<td>N00-N99</td>
<td>Diseases of the genitourinary system</td>
</tr>
<tr>
<td>XV</td>
<td>000-099</td>
<td>Pregnancy, childbirth and the puerperium</td>
</tr>
<tr>
<td>XVI</td>
<td>P00-P96</td>
<td>Certain conditions originating in the perinatal period</td>
</tr>
<tr>
<td>XVII</td>
<td>Q00-Q99</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
</tr>
<tr>
<td>XVIII</td>
<td>R00-R99</td>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
</tr>
<tr>
<td>XIX</td>
<td>S00-T98</td>
<td>Injury, poisoning and certain other consequences of external causes</td>
</tr>
<tr>
<td>XX</td>
<td>V01-Y98</td>
<td>External causes of morbidity and mortality</td>
</tr>
</tbody>
</table>
A Practice Manager Goes to Haiti: Healthcare Beyond the Limits

Nurse, Practice Administrator and now Consultant Donna Izor, MS, FACMPE blogs about her trip to Haiti to provide medical relief.

As medical practice managers, we experience the challenge of providing care to patients each day. The success of our daily work depends upon our knowledge and experience and occurs within the constructs of policies and regulations.

Now imagine working in an environment without job descriptions, JCAHO or HIPAA. It is also without a facility, water or electricity. Patient care demand is high and access is limited or non-existent. Sound interesting? Then consider medical relief work.

The timing had never been right for me, but I was captivated by the stories of others providing needed medical care, doing jobs that may not be their expertise, struggling with a new language and learning about a new culture. Resigning a position as VP of Physician Services to begin my own consulting firm provided the opportunity to fill this dream.
I had no idea when I would go, or where, but knew I wanted it to be within the next six months. I started speaking to friends who had gone on missions and asked they keep me in mind for future trips.

One friend emailed others and asked if they knew of relief missions going out within the next few months. Within a week I received an email that a medical team would be going from the Dominican Republic into Haiti and they were looking for workers.

I contacted the coordinator, a nurse practitioner located in the DR, and told her I was an administrator but had been a nurse though I hadn’t used my skills in 20 years.

She said my nursing skills would be helpful and I agreed to go. Hearing this my husband decided to join in and they were happy to have his skills as an engineer as part of our team.

Within one week I was able to collect over 70 pounds of the requested over the counter medications and dressings from friends, former practices and a local drugstore. People were very willing to help. Others gave us old scrubs that we could use then leave behind. There were some challenges “finding a mosquito net in March when there is still snow on the ground but the planning went well and even the airline helped by allowing additional luggage. In less than two weeks from the initial email we were on our way to join medical teams for one week in Haiti and a second week in bateyes (sugar workers’ town) of DR.
We landed in the DR and traveled to the mission home location in La Romana to meet other team members and to learn about the work in Haiti. Our team consisted of two physicians, two medical students, a pediatric resident, several senior nursing students and their instructor, a pastor, a marketing executive, two nurses from Maine, a nurse from Nebraska and one from Alabama and several staff members of the mission living in the DR. Under the leadership of the coordinator, Kristy, we learned to work together and trust each other.

![Image via Wikipedia](https://via.placeholder.com/150)

We spent the first day repackaging medications into small bags for patient distribution and organizing the food donations that we would also be bringing. A human chain made quick work of loading the two trucks. At 10pm we climbed into a bus to begin our trip. By 8 am were at the Haitian border, joining long lines of waiting trucks. We spent over 6 hours at the border while our coordinator worked hard to gain entry for us. The president of Haiti had declared that the disaster was over and the country was poised to manage the aftermath on its own. Send money, he’d direct it. Kristy knew how dire the circumstances were for the people of Haiti and persevered. We were allowed to enter and our “real” journey began.

There is nothing to prepare you for seeing the effects of an earthquake in a country little
My husband described it as the difference in seeing a picture of the Grand Canyon and being at the Canyon looking over the rim. The vastness and sense of awe is little served by the picture. Port au Prince had been on the news in the three months since the quake yet the expanse of destruction, the poverty and lack of services for the people, and the sheer amount of rubble and garbage filling the streets was confounding.

We arrived in Port au Prince late in the afternoon and settled into the walled compound that would be our home for the week. On the grounds were a church, school, dormitory, kitchen, locked storage building used by the relief mission teams and several tents, home to the workers there. A generator provided electricity to run the fans and the water pump. Regretfully, it was old and often broke down meaning no showers and a very hot sticky night of sleeping.

Donna is on the right in the back of the truck (with glasses.)

Our days began early. After breakfast we loaded the open backed trucks with food, medicines, and tarps and then put in church pews to sit on before climbing in. Interpreters joined us for the rides. At that time, we were the only relief agency going into the neighborhoods to provide care. Because there was concern for the safety of relief workers, Kristy arranged to hire two off duty Haitian police officers for protection. We would ride through the city in amazement at the destruction, surprised not to see any other relief
workers.

Huge water bladders from the Red Cross were located on several streets as well as temporary showers and port-o-lets. Any available space was occupied by a family with a make shift tarp or tent. Houses that had fallen down three months before were still spilled into the street with people walking through the debris.

**People dug in the rubble of homes to release rebar so that it could be resold. This was hard to watch knowing that there were still bodies located there.**

Reaching our destination, Kristy and the lead support person from DR would decide how the clinic would be set up while we waited in the truck, protecting the contents. It took less than 30 minutes to unload the truck and set up the clinic with the entire team helping. Patients would be given a “ticket” allowing them to be seen. Then they would provide their name, age, and describe their current symptoms to a Haitian worker who put it on a yellow card that traveled with the patient. There were many who came because they knew that we had food and water but they were turned away. Hundreds waited in 90+ degree heat in the sun for the opportunity to be seen by the medical team.

After entering the clinic area, patients had their weight and blood pressure taken. The clinic area was a large space with providers sitting on benches next to their interpreter. Each provider had a box of “usual” medications including antacids, multi vitamins and acetaminophen for each age group. Patients waited quietly until they were escorted to a provider. With...
little examination, the provider indicated the likely diagnosis, gave medications from his box, and indicated the prescriptions to be given. The patient would move to the pharmacy where nurses and an interpreter completed the order. Then would then go to the de-worming station for all who were over 6 months old and not pregnant. Finally they moved to the gift station where a bag of food (2 pounds rice, 2 cans beans, and 1 can tomato sauce) was given to each family as well as soap and donated clothing while it lasted.

Providers are on one side with their interpreters and patients on the other. Kristy, our leader, is in yellow.

Each day nurses rotated through the various duties of taking vital signs, the pharmacy, the de-worming station and the gift station. Everyone took time to play with the kids and to live the motto we had been given,

“Do what you can, with what you’ve got, in the moment you’re given”.

We knew that many would not make it back to where they were living with the food they were given, but some would. That the 30 days of medications would run out, but for 30 days it would be all right. That the smiles we were seeing would fade to despair as the rain began, but for today the sun was shining.
The people we took care of were inspirational. If they were living in plastic covered tents, they were lucky. Many were still living under sheets held up by sticks. Their lives were a mess but they easily shared their smiles. The kids loved the attention, and getting them to leave the clinic was often difficult.

Not everyone is lucky enough to have a tent and have made do with what they have. Note the large amount of garbage.

The most common reason for being seen was grippe, a diagnosis that included any respiratory symptom and fever. Without an x-ray for confirmation, all patients were treated with antibiotics. We saw wound infections from surgery or treatments that occurred after the earthquake but had not been treated since. Dehydration, malnutrition, starvation, scabies, high blood pressure, upper gastric pain, and vaginal infections were some of the other diagnoses.

Treatment was basic. We had limited medications so routinely substituted others as inventory ran out. The clinic was loud but ordered. The organization that was developed by running these clinics over time was amazing given the conditions. What became hardest was leaving. We had to be back to the compound by dark and often this meant we had to pack up and leave a site before everyone could be seen.
Adults asked for care, children begged for water and food, yet many stayed to say thank you.

Our ride back to the compound included a stop at the General Hospital in Port-au-Prince where patients with severe illnesses were taken. You must realize that part of the hospital had collapsed and it did not have running water or electricity. The doctor who had seen them in the clinic accompanied Kristy into the ED to discuss the case with the physicians there. Often, the doctors at the hospital were from the US or Canada but doctors from there and many other nations were said to be working together. Once such case was a 5-month-old infant who had returned to birth weight. Another woman had an infection at a surgical site that would probably require amputation of her foot; another was a 3 year old with cellulitis surrounding her eye. We left them knowing that family members may not know where they were and that a ride back to where they were living would be difficult to come by.

Fallen house, one of many.

Our trip back to the compound again brought us through the streets of Port-au-Prince. We saw downed houses, people selling anything and everything under colorful umbrella, and the mounds of plastic water bottles and Styrofoam containers garbage from the initial relief after the earthquake but now filling the canals meant to drain the city during the rainy season. We saw tent cities in areas that would be flooded with no place for these people to go. Others had set up their shelters in the median of the road. People shouted out to us
for water and food, or just a greeting. We passed armed UN soldiers driving in jeeps through the city. The devastation was everywhere you looked.

When we returned, it was time to unload the trucks. If there was water, the lines for the shower began. People worked to repack the supplies for the next day and to enjoy a mango from one of the many trees on the compound. Dinner was always delicious and followed by a group meeting to discuss what we had seen and done for the day.

**People shared their thoughts and some cried when discussing the level of illness, the people not able to be seen, or what we had seen on the ride to or from the clinic.**

Several evenings the church came alive with music and prayer. I worked on a project to collect age, diagnosis and medications data to be used for Kristy to write grants and try to gain additional monies for future trips. Bedtime was early, and we were ready to sleep, as we would have an early start the next day. It was hot, especially when the fans were not working, but we had food, water and a roof over our heads. So much more than those we had cared for.

Leaving Haiti was difficult. There was so much more to do. There would always be so much more to do until the structure of the country became stable and one that would support all of its’ people. The ride back to the DR was much quieter. The border crossing into the DR was quick and easy. Only a flat tire slowed our travels.
Once back we unloaded the trucks, took long showers, and continued to debrief from the experience. Only my husband and I would be staying an additional week to work in the bateyes, so we began saying our good-byes to our teammates. I know that we will keep in contact with many as the years go by and our hope is to come together again in the future for another relief mission.

So can an administrator with past nursing experience learn from a relief mission? Yes, first about yourself and how you will endure conditions that you could only imagine.

Second you learn about others and the real meaning of doing what you can, for those that you see, with what you have and for that moment. I encourage each of you to embark on your own journey. You don’t need to leave the United States, there are many organizations that need help right here and I’m sure some right in your town. Be it a medical relief mission or participation on the local level, you will learn so much and it is so worth it.

Donna Izor, MS, FACMPE recently started West Pinnacle Consulting, LLC after 20 years as a medical practice executive. Her experience includes responsibility for primary care and specialty practices, employed inpatient physicians, regulatory oversight, facility design, physician compensation and relations, and new program development. She has worked with academic, community hospital, and private practices. You can contact Donna at donna.izor@gmail.com.
91 Physician Organizations Sign Statement Naming Congress in “Mismanagement of the Medicare Program” and Imploring it to “Honor its Obligation”

UPDATE: On June 25, 2010, President Obama signed into law the “Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (H.R. 3962)” which includes a delay in the 21+% Medicare fee cut until November 30, 2010. CMS will have the MACs start processing new claims with dates of service of June 1, 2010 and later at the 2009 fee schedule plus a 2.2% increase. The MACs will also have to reprocess the claims already paid for dates of service June 1, 2010 and later that were processed with 2010 fee schedule and that big fat cut.

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Note: On June 16, 2010 the Senate failed to pass a proposal that would increase the Medicare reimbursement for physicians by 2.2% for the balance of calendar year 2010 and by 1% for calendar year 2011. Senate leadership is now working on a plan to extend the freeze until year-end. The following statement was released by the state medical societies of all 50 states and the District of Columbia, as well as 41 specialty physician organizations.
Statement of the State and Specialty Medical Societies on the Medicare Physician Payment Crisis

Failure by Congress to fulfill its responsibilities is undermining patient care in America. Three times this year, Congress has missed a deadline for dealing with Medicare’s sustainable growth rate (SGR) formula, raising the specter of a 21 percent payment cut for physician services. The disruption and uncertainty for patients and physicians has made Medicare an unreliable program.

If Congress does not act this week, Medicare physician payments will be cut 21 percent. These cuts will also extend to the TRICARE program which serves military families, as well as some Medicaid programs, workers compensation programs and private insurance plans. The ripple effect of the 21 percent Medicare cut will be devastating to physician practices.

Congressional mismanagement of the Medicare program will force more physicians to stop accepting new Medicare and TRICARE patients; lay-off staff; and defer investment in new medical equipment, health information technology, and other innovations that improve patient care.

Patients and physicians should not become collateral damage in a Congressional stalemate on budgetary matters. We expect our elected officials to resolve the budget issues without punishing physicians, seniors and military families.

Past actions by Congress created the current budgetary challenge. Further, since 2003, Congress has compounded this problem by employing budget gimmicks that defer immediate cuts
by stipulating deeper cuts in future years.

Democrats and Republicans agree that the flawed Medicare formula that is responsible for pending cuts should be repealed. The annual SGR battle diverts attention from more productive delivery and payment reform initiatives. We must move to a payment system that fosters innovation and rewards physician efforts to lower the rate of growth in Medicare spending across the existing silos in the program.

Medicare must adequately cover the cost of care and close an existing 20 percent gap as measured by the government’s own conservative measure of annual increases in medical practice costs.

We must also allow seniors who wish to contract directly for their care with a physician of their choice to do so without foregoing the Medicare benefits for which they paid during their working years. Medicare benefits were earned by and belong to Medicare beneficiaries. They must be allowed to assign these benefits as they see fit.

Playing brinksmanship with the health care of seniors and military families is inexcusable and represents a dereliction of duty. We urge Congress to honor its obligation to provide access to quality care to America’s seniors and military families by taking action to fix the Medicare physician formula problem now!

American Academy of Dermatology
American Academy of Facial Plastic & Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice & Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Pain Medicine
American Academy of Pediatrics
American Academy of Physical Medicine & Rehabilitation
American Academy of Sleep Medicine
American Association for Hand Surgery
American Association of Clinical Endocrinologist
American Association of Clinical Urologist
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodiagnostic Medicine
American Association of Public Health Physicians
American College of Cardiology
American College of Emergency Physicians
America College of Gastroenterology
American College of Obstetricians & Gynecologists
American College of Occupational & Environmental Medicine
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Institute of Ultrasound in Medicine
American Medical Association
American Orthopaedic Foot & Ankle Society
American Society for Clinical Pathology
American Society for Reproductive Medicine
American Society for Surgery of the Hand
American Society of Addiction Medicine
American Society of Cataract & Refractive Surgery
American Society of Cytopathology
American Society of Ophthalmic Plastic & Reconstructive Surgery
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
North American Spine Society
Renal Physicians Association
Society of American Gastrointestinal Endoscopic Surgeons
Society of Nuclear Medicine

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association, Inc.
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society

Medicare: Participating, Not Participating and Opting Out

If the provider participates ("par"), he agrees to accept the Medicare-approved amount as payment in full ""called accepting assignment "" and Medicare will pay 80 percent of this approved amount, after the deductible is met. The patient is responsible for the deductible and the other 20 percent. The provider cannot charge patients any more than the Medicare-approved amount.

If the provider does not participate ("non-par"), he does not accept the Medicare-approved amount as payment in full (does not accept assignment), but nonetheless treats Medicare patients. He can charge up to 15 percent more for his services (called the limiting charge) than the Medicare-approved amount and can request full payment up front from patients. He probably should request payment in full, because Medicare will
send the payment to the patient when the provider does not accept assignment.

If the provider opts out of Medicare entirely, he is not subject to the Medicare limits on charges and does not submit claims to Medicare. In this situation, the provider asks the patient to sign a private contract in which the patient accepts responsibility for the full cost of the services. In the case of this contract, Medicare will not pay for any portion of the services the patient receives.

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**CMS Delays Claim Payment Until June 17th, Hoping for Congress Movement to Further Delay or Repeal (?) the SGR Formula**

UPDATE: On June 24, 2010 the House and Senate passed legislation to further delay the Medicare cuts until November 30, 2010. More here.

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Excerpt From Today’s CMS Announcement (with my bolding):
The Centers for Medicare & Medicaid Services (CMS) is hopeful that Congressional action will be taken within the next several days to avert the negative update.

Given the possibility of Congressional action in the very near future, CMS is now directing its contractors to continue holding June 1 and later claims through Thursday, June 17, lifting the hold on Friday, June 18.

This action will facilitate accurate claims processing at the outset and minimize the need for claims reprocessing if Congressional action changes the negative update. It also should minimize the provider and beneficiary burdens and costs associated with reprocessing claims.

We understand that the delayed processing of Medicare claims may present cash flow problems for some Medicare providers. However, we expect that the delay, if any, beyond the normal processing period will be only a few days. Be on the alert for more information regarding the 2010 Medicare Physician Fee Schedule Update.