News For The Day: From the desk of Elizabeth Woodcock

21.2% Medicare Cuts: April 1 is Looming

On the precipice of a significant cut in reimbursement on April 1, the Senate left Washington, DC, last week without addressing Medicare reimbursement. This disappointment followed a week of events that left physicians and industry advocates breathless with excitement. The Medicare Access and CHIP Reauthorization Act, HR 2
was passed overwhelmingly by the House of Representatives on March 26. After more than a
decade of tireless advocacy surrounding this issue, the legislation offers a permanent fix to the
SGR – the sustainable growth rate – an element in the payment formula that drives the
ridiculous decreases in Medicare cuts to physicians. At a massive cost to the American public,
these cuts have had to be reversed a remarkable 17 times. For years, everyone has agreed that
the formula was flawed, but there was no action to reverse it.

HR2, the legislation that passed the House, provides for an elimination of the SGR cuts,
replaced by a five-year period of annual increases of 0.5% through the transition to a
replacement payment methodology. In addition, the legislation expands the popular CHIP –
Children’s Health Insurance Program – for two years, expands funding for community health
centers (CHC), extends the existing Geographic Practice Cost Index (GPCI) floor until January
1, 2018, reverses the Centers for Medicare & Medicaid Services’ (CMS) decision to phase out
global surgery payments in 2017 and 2018, focuses additional resources on EHR
interoperability and re-introduces the concept of a “combined” quality incentive program entitled
“Merit-Based Incentive Payment System,” an idea that Congress had proposed last year. An a
mendment to delay the implementation of ICD-10 until October 1, 2017
, was proposed by Representative Palmer (R-AL), but it is not in the final legislation that was
passed, noting that it was just last spring when a delay was indeed passed in a similar fashion.

The current “patch” expires on April 1, at which time physician payments will plummet by 21.2%
for services provided to Medicare patients. That doesn’t include the sequestration cuts of 2%,
which have been – and will continue to be – applied to every Medicare payment through 2024.

If history is any predictor, CMS will announce a payment hold for at least two weeks in order to
allow the Senate to vote. Otherwise, Medicare contractors must load the new, reduced fee
schedule for services provided as of April 1, 2015. While claiming that this won’t affect
payments because the payment cycle is approximately 14 days, it always has an impact on
reimbursement, as well as administrative costs, particularly if claims have to be reprocessed. Furthermore, if the legislation does indeed pass, CMS will request time for its Medicare contractors to load the new fee schedule, proposed to be 0.5% higher.

Having already left Washington, DC, there is little to do but to wait – and hope – that the Senators will take up this legislation upon their return. The Senate reconvenes on April 13, 2015, with Senate Majority Leader Mitch McConnell’s (R-KY), promise on Friday before leaving for the break: “We’ll turn to this legislation very quickly when we get back.” According to the Congressional monitoring service, Govtrack.us, the bill has a 79% chance of being enacted. As we await the decision, recognize that this will surely impact your cash flow in April, regardless of the final decision.
March 20th, 2015. As we approach the implementation of ICD-10 my office will be sending out weekly emails to all of our offices with very important information on this subject. Please be looking for all the attachments as well as vital information for your office to use to implement the new code sets into your daily routine. These code sets need to be used to update your current fee tickets as well as your EMR system. Contact our office for further information and for one on one help with any of your ICD-10 needs.

NEWS FOR THE DAY: July 21, 2014 FROM ELIZABETH WOODCOCK-SVMIC

2015 Medicare Physician Fee Schedule Proposal Released

On July 11, 2014, the Centers for Medicare & Medicaid Services (CMS) published the proposed 2015 Medicare Physician Fee Schedule Rule.

CMS reveals little about its EHR Incentive Program in the proposed rule, other than mentioning its support of health information exchange (HIE). It is widely expected that CMS will release an update on the EHR program to follow its highly publicized proposed rule issued on May 20, 2014, which pushed back the meaningful use timeline.

2015 Medicare Physician Fee Schedule Proposal Released

On July 11, 2014, the Centers for Medicare & Medicaid Services (CMS) published the proposed 2015 Medicare Physician Fee Schedule Rule.

PAMA also gives CMS the right to examine the value of nine new categories of codes – the so-called “misvalued” codes, which are set to be relooked at in the context of the Resource-Based Relative Value Scale Update Committee (RUC). CMS asserts that this new process will achieve “added transparency in [the] development of payment rates.”

As announced in the 2014 Medicare PFS final rule, chronic care management will be reimbursed as of January 1, 2015. However, CMS announced a negative 20.9% update for the remainder of 2015 following the expiration of PAMA.

Changes to relative value units leave most specialties whole, with the exception of radiation oncology.
For practices that have converted to provider-based services – a common strategy to boost reimbursement for hospitals ...

Perhaps the most unanticipated revelation in the proposed PFS is CMS' intention to assess the payment system for...

Other issues include an expansion of data made available to the public on Medicare's Physician Compare website; a remarkably substantial number of changes for PQRS, which converts from a bonus program to a payment-adjusting initiative in 2015 (in other words, no more bonuses for...

For more information, click for a link to the Proposed Rule, which was released to the public on July 3, and officially published on July 11, 2014.

It's important to note that these are all proposed changes; the final rule is expected to be released by November 1.

July 14, 2014. News for the day. We are pleased to announce the recent addition of two very highly respected ambulance services located here in Memphis to our group of clients. These two services have rapid growth within their businesses. Myself and my staff here at MIFS are going to make sure that they are compliant and billing properly and want to extend a great welcome to all of their office staff and owners. Additionally we have recently added several new employees to our staff bringing the number of employees at our office to 40. We will continue to help all our offices be compliant and run their billing areas as efficient as we can. As we move forward and anticipate the implementation of ICD-10 in 2015 we will again be bringing our guest speaker from Rhode Island in to further ours and our clients knowledge of all areas of this transition.

On the eve of March 31, 2014 the US Senate passed the Protecting Access to Medicare Act. This averted the 24% Medicare cut that was to take place on April 1, 2014. There is no less and no more payment for services rendered and the 2% sequestration cut is left in place. This is the 12th year in a row this has taken place with no resolution and no permanent fix. It also delayed the implementation of ICD-10 which some industry leaders are up in arms about. While this was a big relief for many small physician practices many larger organizations have spent millions of dollars on implementation and training for the October 1, 2014 deadline. It also
leaves a big question as to whether or not ICD-10 will be implemented on the proposed October 1, 2015 date or if they will wait until 2017 when ICD-11 comes out. Either way CMS has a lot of work to do and a lot of questions to answer with respect to all these issues. Finally, please be prepared from April 1, 2014 to April 15, 2014 for your Medicare claims to be held due to all this. It should not affect you to much as their is a 13 to 17 day hold for clean claims either way. Claims for dates of service March 31, 2014 and back will be processed as usual.

2-19-2014 As of December 2013 the new Murray/Ryan budget deal has been established. While it still has to pass both the Houses, and President Obama, this bill seems to be one that will make into law.

This new law will give providers a 0.5 % increase each year for the next five years. Please keep in mind that we all face federal sequestration on all Medicare payments in the amount of 2%. This applies to all Medicare payments including incentive payments, and meaningful use payments as well. Also keep in mind that although this gives physicians some peace of mind and will allow them to more effectively run their practices, there is still the lingering RVU issue. These RVU's change from year to year and based on that change physicians can still possibly expect to see less revenue on some services.

01-29-2014 My office would like to invite all our clients and anyone else interested to a seminar on ICD-10. Our guest speaker will be Nancy M. Enos, FACMPE,CPMA,CPC-1, CEMC.

Nancy is a resident of Warwick, RI and is one of the best key note speakers around on these topics.

The event will be held on March 18, 2014 at The Holiday Inn University, 3700 Central Avenue, Memphis.

Registration is at 6 pm, meeting at 6:30 pm.
There will be a $100.00 fee and this includes your ICD-10 publication. Light food and refreshments will be served. Please contact my office for further information.


President Obama Signs the Pathway for SGR Reform Act of 2013

--New Law Includes Physician Update Fix through March 2014--

On December 26, 2013, President Obama signed into law the Pathway for SGR Reform Act of 2013. This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2014. The new law provides for a 0.5 percent update for such services through March 31, 2014. President Obama remains committed to a permanent solution to eliminating the Sustainable Growth Rate (SGR) reductions that result from the existing statutory methodology. The Administration will continue to work with Congress to achieve this goal.
The new law extends several provisions of the *Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act)* as well as provisions of the *Affordable Care Act*. Specifically, the following Medicare fee-for-service policies have been extended. We also have included Medicare billing and claims processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, and more information about other provisions will be forthcoming.

**Section 1101 – Medicare Physician Payment Update** – As indicated above, the new law provides for a 0.5 percent update for claims with dates of service on or after January 1, 2014, through March 31, 2014. CMS is currently revising the 2014 Medicare Physician Fee Schedule (MPFS) to reflect the new law’s requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2014 conversion factor is $35.8228.

**Section 1102 - Extension of Medicare Physician Work Geographic Adjustment Floor** – The existing 1.0 floor on the physician work geographic practice cost index is extended through March 31, 2014. As with the physician payment update, this extension will be reflected in the revised 2014 MPFS.

**Section 1103 - Extension Related to Payments for Medicare Outpatient Therapy Services** – Section 1103 extends the exceptions process for outpatient therapy caps through March 31, 2014. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through March 31, 2014. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD). Additional information about the exception process for therapy services may be found in the [Medicare Claims Processing Manual](#)
The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received on January 1, 2014. For physical therapy and speech language pathology services combined, the 2014 limit for a beneficiary on incurred expenses is $1,920. There is a separate cap for occupational therapy services which is $1,920 for 2014. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 1103 also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2014 through March 31, 2014, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services, including OPD therapy services, for a year. There are two separate $3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

**Section 1104 - Extension of Ambulance Add-On Payments** - Section 1104 extends the following two Job Creation Act ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas is extended through March 31, 2014; and (2) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25 percent of all rural areas arrayed by population density (known as the “super rural” bonus) is extended through March 31, 2014. The provision relating to air ambulance services that
continued to treat as rural any area that was designated as rural on December 31, 2006, for purposes of payment under the ambulance fee schedule, expired on June 30, 2013.

Section 1105 - Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals - The Affordable Care Act allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges from the hospital. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment through March 31, 2014, retroactive to October 1, 2013. Be on the alert for further information about implementation of this provision.

Section 1106 - Extension of the Medicare-Dependent Hospital (MDH) Program - The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until March 31, 2014, and is retroactive to October 1, 2013. Be on the alert for further information about implementation of this provision.

12-19-2013 Please make sure you prepare for 2014 by going over all you current CPT coding with us if you have not already done so. There were tons of changes in most areas so please make sure your EMR's and superbills are updated. Finally, we are hosting a speaker here in Memphis on March 18, 2014 for ICD-10. There will be a small fee as we had to bring her in from out of town. This will be a great even to attend. Please let us know if you can make it and we will put you on the list. October 1, 2014 is the start date and this will greatly impact your practice and cash flow if you do not comply with these new codes. You should prepare by making sure you have enough capital on hand for a 3 month period to give the carriers time to adjust to processing claims with this new code set. Happy holidays to all of you and have a joyous New Year.
5-16-2013 As you all know the sequestration budget cuts hit us on April 1, 2013. These cuts made it possible for your Medicare payments to be reduced by 2% across the board for all services rendered by you. The bonus program payment was also impacted by sequestration. Physicians attesting for reporting periods that end on or after April 1, 2013 will see a 2% reduction in their bonus checks, which are $15,000, $12,000 or $8,000, depending on the year you started participating in the program. The Medicaid EHR Incentive program was not affected by this. Also of note is that you must have your E-RX numbers complete by June 30, 2013 to avoid any penalty on your checks for this period. One last bit of information is PQRS. You will need to start preparing your practice's for yet another cut if you do not comply with the newest demands for your practice to show quality measures on your patients.

5-13-2013 Please be watching for upcoming events to be hosted by myself here at our offices. We will be putting on a seminar for ICD-10 implementation sometime in late summer and also hosting a how to survive seminar for small group and single practice physicians. Please let us know if we can help you with any of your billing needs. We also can help with new and innovative cost centers to help bring in revenue to your clinic.

3-1-2013 Contract negotiations are an essential part to making sure you are getting the maximum amount paid for your hard earned work. Here are a few tips to make sure you do just that. First, make sure that you know what codes are bundled and will not be paid. Especially for your high dollar or high volume procedures. Secondly, make sure your fee schedule year is the current year and not based on fee schedules from the past such as Medicare rates from 2007. This is done time and time again by major carriers to unsuspecting practices. Thirdly, make sure that the conversion factor being used by your carrier is the current years conversion factor. A change in CF can have a significant impact on your practice's reimbursement because it affects every code billed by you. Fourth, Practices should challenge any contract offered that sets fees based on the lower facility total RVU's, which reflect hospital/outpatient surgery center cost structures. The reimbursement for every code you bill varies according to the code's RVU's so this is a very important. As a practice you want to make sure you are being reimbursed based on the higher non-facility total RVU's which take your overhead costs into consideration. Finally, Ask you payers if they are using GPCIs or Geographic practice cost indexes. These reflect variations in Medicare reimbursement so it is very important to ask whether your payers are using them or not.

In other news please note that the current sequester looming over all of us with respect to Medicare fee's is upon us today. If not fixed it will cause a 2% reduction in your Medicare reimbursement's. That being said please remember that you all received a 3.2% raise in some cases from 2012 to 2013. For example, in 2012 a 99213 allowed amount was $65.75 and in
2013 it is now $67.86. So in reality the 2% reduction amounts to a small raise for many of you. Let's hope our friends on Capital Hill can get this fixed before March 14th, 2013 rolls around.

1-24-2013 I hope this message finds all of you well. The new year has brought many changes to our industry and as they come about I have made every effort to bring these changes to your attention. Any news bulletins you may come across that you receive in office that may be beneficial to me please let my office staff know as there are thousands out there.

Communication is the key here and although I try very hard to stay informed sometimes my staff and I miss one now and then. Here is wishing Congress can get it together and find a permanent solution to all our seemingly endless problems with reimbursement.

1-9-2013 Happy New Year to you all !!!!!!! Please read the message from SVMIC's Elizabeth Woodcock, MBA regarding the 2013 SGR ruling.

Although the political wrangling and uncertainty dragged into the New Year, physicians across the nation were relieved that a massive reduction in Medicare reimbursement was averted for 2013. Signed into law on January 2, 2013, the American Taxpayer Relief Act (ATRA) of 2012 halts a scheduled 26.5 percent decline in Medicare physician payments.

While the legislation merely delays the Sustainable Growth Rate (SGR)-generated cuts until next year, the relief felt by physicians and other health care professionals was certainly palatable. The ATRA sets the 2013 conversion factor at $34.0230, leaving Medicare payments flat for the coming year. In addition to the “zero percent” update to the Medicare Physician Fee Schedule (MPFS), the passage of ATRA also addresses other key issues:

**GPIs.** The 1.0 work Geographic Practice Cost Index (GPCI) floor is extended for a year, which primarily benefits physicians practicing in western states.

**Carrier rate postings.** The Centers for Medicare and Medicaid Services (CMS) set a deadline of January 23, 2013 for Medicare carriers to release the new fee schedule rates. Expect to see carriers posting the new rates on their websites in the coming days.
Participation enrollment. CMS will extend physicians’ 2013 annual Medicare participation enrollment until February 15, 2013 – it was formerly December 31, 2012.

RVU changes. The Act confirms that the changes announced in November regarding the relative value units (RVUs) will remain in effect. Primary care specialties get the most benefit while radiation oncology takes the largest hit. (elizabeth@elizabethwoodcock.com?subject=2013 Medicare RVU Changes”>Email me if you want a copy of the changes listed by specialty, according to a CMS calculation based on historical Medicare claims.)

Claims processing delays. CMS warns that slight delays may occur as it develops, tests and implements the revised fee schedule. CMS will allow claims processing contractors to hold on to Medicare claims with January 2013 dates of service for up to 10 business days, but those claims will be released into processing no later than January 16, 2013. Because Medicare takes 14 calendar days to pay clean electronic claims (29 days for paper claims), the delay should have only a minimal impact on physicians and other health care professionals treating Medicare beneficiaries.

Outpatient therapy caps. The exceptions process for outpatient therapy caps is retained through December 31, 2013. The process requires outpatient therapy service providers to submit a KX modifier on therapy claims when requesting an exception to the annual cap in order to get reimbursed for furnishing medically necessary services.

In announcing the new law and the resulting zero percent update for 2013 Medicare physician claims, CMS declared that “President Obama remains committed to a permanent solution to eliminating the SGR reductions that result from the existing statutory methodology.” As the economy recovers, one hopes that this now-annual issue of Medicare payment declines will finally be resolved in 2013.
11-28-2012 I hope everyone had a great Thanksgiving and we wish you all a very Happy Holiday season. I am watching very closely the news with respect to the cuts you may face here in the next several months. I will keep everyone posted as to what is happening on Capital Hill.

8-27-2012 My office, in collaboration with several other entities, will soon be hosting an Independent Physician's meeting. This meeting is being held to focus on the physicians in our area that wish to remain independent and still have a voice in their practices as well as in the community. I will keep everyone posted on when and where this meeting will be held. We hope that everyone can attend and certainly hope this will provide you with alternatives to the ever changing healthcare world we are dealing with now. We are also going to be hosting an ICD-10 seminar here very soon. The date has been finalized for ICD-10 implementation. It is now October 1, 2014. I know this is several years off but we intend to make sure that we are far ahead of the game by introducing this and making our physicians aware of what is going to take place. It is a major change and could cause financial disaster if it is not reported properly. Stay tuned to my web site for further details.

7-16-2012 Implementation of ICD-10 is underway here at my office. Organizing and Analyzing the impact ICD-10 will have on all of us is a big undertaking. We have made sure that we have contacted our system vendors, budgeted for this, contacted my trading partners and begun the process. We will be implementing the system and conducting internal testing later this year and updating our internal processes as well. Training of my staff as well as my clients will begin later this year as well. I will keep all of you posted as we are going to have a big seminar with a very knowledgeable guest speaker that will help all of us to transition over to this new way of reporting diagnosis code sets with your charges.

4-16-2012 We are finally over the hump with all the 5010 conversion issues for now. This does not mean we can rest but it seems as though the clearing houses and Medicare carriers have finally gotten together on all this. The primary and secondary issues are resolved. We now are dealing with the box 33 issue of the physical address being in this field in place of the pay to
address. Although, as you all know, we notified all carriers of the proper pay to address, they all seem to have minds of their owns when it comes to where they send payments. We are on top of this and will make sure all payments are received in a timely fashion. Our next issue is ICD-10 which was set for October 2013. This has been delayed and we hope it will be delayed for several years. I will keep everyone posted on all the issues.

2-14-2012 Happy Valentines Day to everyone. Hope you have a sweetheart of a day.

1-24-2012 To all our clients: We finally can breathe a sigh of relief on the 5010 issue for now. All the Medicare issues have been resolved to this point and we feel we are on a good road to reimbursement. This does not mean we will not have any more problems with the 5010 conversion. News from around the industry is good in some places and bad in others. There are still clearing houses and physician offices that cannot get clean claims though for processing to some major carriers. Most seem to be having problems with the Medicare or governmental carriers at this time. I will keep everyone posted by way of e-mail and fax and on our website here. Thanks for your continued support and patience with all this as we transition to this new era of claims filing. Please remember to keep turning in your E-RX codes when you do this on your patients to avoid the penalty being imposed by your government.

As Reported by MedScape: December 9, 2011 — House Republicans today unveiled a “doc fix” for the Medicare reimbursement crisis that would not only avert a 27.4% pay cut on January 1 but also raise rates by 1% annually through 2013.

The measure is part of an omnibus bill that would, among other things, extend unemployment benefits as well as a temporary cut in the Social Security payroll tax through 2012. House Republicans, who command a majority in that chamber, intend to vote on the bill next week. If passed, the bill faces Democratic opposition in the Senate, which that party controls, and a threatened veto from President Barack Obama.

Earlier this week, House Republicans were considering a doc fix that would merely freeze Medicare rates over 2 years. The Congressional Budget Office (CBO) had put its cost at $38.6 billion over 10 years.

The latest doc fix from the GOP is more generous, with a 1% raise in both 2012 and 2013. The
CBO priced that at $38.9 billion.

The bill requires the Medicare Payment Advisory Commission, the Governmental Accountability Office, and the Department of Health and Human Services to help Congress devise a new way to set Medicare rates for physicians. The method used now — the sustainable growth rate (SGR) formula — is what triggered the 27.4% cut scheduled for 2012.

Organized medicine as well as the GOP Doctors Caucus, which consists of 21 physicians and other clinicians in the House, has lobbied hard for a permanent repeal of the SGR formula. Its cost — almost $300 billion for merely freezing rates through 2021 — appears too expensive for a budget-minded Congress to stomach right now, especially because fiscal conservatives insist that every increase in spending be offset elsewhere in the federal budget.

Rep. Phil Gingrey, MD (R-GA), co-chair of the GOP Doctors Caucus, told Medscape Medical News that he does not expect "physicians to be jumping up and down and claiming victory" over the 2-year doc fix with its modest raise. However, the temporary solution will keep most physicians from abandoning Medicare and give policymakers more time to replace the SGR formula with one that rewards clinicians for the quality of their care, according to Dr. Gingrey.

"We're committed [to repealing the SGR]," he said. "We're trying to turn the Titanic. It's a very slow, wide turn, but we're going to get there."

What Does Crude Oil Have to Do With Medicare?

Congressional Republicans and Democrats alike pay lip service to avoiding a massive reduction in Medicare pay that would drive physicians out of the program. The challenge is getting these political lips to agree on how to finance the solution.

The omnibus bill released today, titled the Middle Class Tax Relief and Job Creation Act of 2011, contains a wide range of "pay-for's" to offset its cost. The bigger pay-for's include $36 billion from changing the co-pay structure for civilian federal retirees, $31 billion from gradually
raising Medicare premiums for high-income beneficiaries, and $26 billion from extending the current pay freeze for federal employees through fiscal 2013.

A summary of the bill issued by House Republicans lists several 'offsets designed specifically to pay for the $38.9 billion doc fix. Two fall under the category of what the GOP calls defunding the Affordable Care Act (ACA). The bill would trim $8 billion from the $18 billion allotted to the new Prevention and Public Health Fund. It would raise another $13.4 billion by recouping more money from individuals who receive more in federal tax credits for insurance premiums than they qualify for.

Other offsets take their toll in the hospital industry, which has lobbied Congress not to fund a doc fix at its expense. The bill calls for reducing the Medicare facility fee that hospitals receive for outpatient evaluation and management services, reimbursement for bad debt caused by Medicare patients who do not pay their share of the bill, and special allotments to hospitals with a disproportionate share of low-income patients.

Dr. Gingrey acknowledged that hospitals have a "legitimate gripe" about reduced federal outlays.

"There will be some angst and heartburn," he said, noting that as a congressman, he represents hospitals as well as physicians in his district. "It's hard on each and every occasion to please everyone." However, Dr. Gingrey suggested that fairness played into the decision to reduce bad-debt payments to hospitals. "Physicians have never gotten that," he said. "[Bad debt] is a total loss to them."

Congressional Democrats also cite fairness in their opposition to the GOP bill, saying that it does not exact enough financial sacrifices from the ultra-wealthy. Senate Democrats this month have tried to fund an extension of the payroll tax cut with a new surtax on millionaires, only to get road-blocked by their Republicans.

Today the White House made the same fairness argument as it went on record opposing the Republican legislation. White House spokesperson Jay Carney also criticized the bill for requiring speedy consideration of the proposed Keystone XL pipeline, which would carry Canadian oil to Texas and create thousands of US jobs. The Obama administration has put off
the decision until 2013 so it has more time to weigh environmental factors and consider an alternate route. On Wednesday, Obama said he would reject any bill marrying the pipeline issue to the extension of the payroll tax cut.

---

**Journalist**

**Robert Lowes**

Robert Lowes is a journalist for Medscape Medical News. A former senior editor at Medical Economics magazine and contributor to numerous healthcare publications, Robert has covered medicine from almost every conceivable angle — public policy, managed care, education, ethics, medical malpractice, information technology, billing and collections, waiting-room design, and first-degree murder. His articles have won major awards such as first place in the annual journalism competition of the National Institute for Health Care Management, and several have been republished in books. Robert also is an anthologized poet. He can be contacted at rlowes@medscape.net.

Robert Lowes has disclosed no relevant financial relationships.

---

12-6-2011 Please read carefully.

December 6, 2011 — A last-minute plan is shaping up in Congress to postpone a massive reduction in Medicare reimbursement to physicians for 2 years, and freeze rates in the meantime.

The political will to avoid a **27.4% pay cut** scheduled for January 1 seems to be there on both sides of the aisle. Last week, House Majority Leader Eric Cantor (R-VA) said that Congress would pass legislation by December 16 to avert what physicians consider a catastrophic blow to their practice finances and seniors' access to care. The question is how Republicans and Democrats will strike an agreement while they are fighting tooth and nail over other end-of-year matters, such as extending a payroll tax cut for workers, and unemployment benefits for the jobless.

Rep. Phil Roe, MD (R-TN), vice chair of the GOP Doctors Caucus in the House, told Medscape Medical News that legislation on these controversial issues might be combined with a "doc fix" to the Medicare reimbursement crisis that would freeze rates at their current levels through 2013. Dr. Roe, an obstetrician-gynecologist, said he would prefer a separate vote on the doc fix to keep it out of
partisan crossfire over the payroll tax cut and unemployment benefits. However, he suggested that lawmakers who are intent on an omnibus bill view the bipartisan support of a doc fix as leverage.

"However it ends up, if we have to be there (in Washington, DC) on Christmas Day, we'll get a doc fix done," said Dr. Roe.

A 2-year fix, he said, would give lawmakers enough time to craft a replacement for the sustainable growth rate (SGR) formula for setting Medicare fee-for-service rates. That formula establishes an annual target for Medicare spending on physician services based partly on growth in the gross domestic product (GDP). Organized medicine considers that a bad metric, arguing that medical-practice costs have risen faster than the GDP. If actual Medicare spending on physician services exceeds the SGR target, next year's spending target shrinks accordingly.

The SGR formula has triggered rate reductions every year since 2002, but starting in 2003, Congress has delayed every one. Each postponement makes the next reduction even deeper.

Dr. Roe said Congress would consult with organized medicine to devise a new formula that compensates physicians for the value of their services, not their volume, which is what fee-for-service reimbursement encourages.

"This Is Not About Doctors Driving Expensive Cars"

Freezing Medicare rates through 2013 as opposed to reducing them as planned would cost $38.6 billion over 10 years, according to an estimate issued last week by the Congressional Budget Office. In a Congress arguing over every dime in the federal budget, that 11-figure amount means a lot of jawboning.

In 2010, when Congress voted 5 different times to stave off Medicare pay cuts, Republicans always demanded that Congress make up the cost with "pay-for's" as opposed to adding it to the deficit. This time around is no exception. Some of the pay-for's under consideration involve partially defunding healthcare reform. Republicans, for example, have proposed reducing the
budget for the Center for Medicare and Medicaid Innovation, created by the Affordable Care Act. Another pay-for would increase how much money the government could recoup from individuals who receive more in federal tax credits for insurance premiums than they warrant.

"There are probably 10 or 12 others," said Dr. Roe.

Echoing organized medicine, Dr. Roe stresses if that Congress allows Medicare rates to fall by 27.4% next year, physicians will not be able to keep their doors open for seniors, especially in light of how their Medicare reimbursement has increased by only 2% over the last 10 years.

"This is not about doctors getting rich," said Dr. Roe. "This is not about doctors driving about expensive cars. It's about being able to afford to see Medicare patients."

Authors and Disclosures

Journalist
Robert Lowes

10-14-2011 5010 Testing is ongoing and we are making great progress in achieving the same standard of excellance we have always given to our clients. Our migration has been completed and we are now just waiting for January 1, 2012 to roll around. We will keep you all updated on news about this as we get it. My office is also going to have a seminar on ICD-10 at a local venue here in Memphis that will be informative as well as enlightening on this new way of reporting the diagnosis on your patients. Please plan to send anyone on your staff that is involved in coding and billing in your office as this will be a major change in the way we report to the carriers. I will again keep you all posted on these two areas.

7-11-2011 CMS has released the Medicare proposed physician fee schedule for 2012. The ruling estimates the 2012 conversion factor to be $23.9635, which represents a 29.5% cut to
Medicare physician payments unless Congress intervenes. CMS will accept public comments as always on the rule until August 30th, 2011. Please get your comments in before this time so we can work together to avoid this disaster.

6-22-2011 Please remember that you have until June 30, 2011 to report on the e-prescribe measures for your practice to avoid the penalties. Remember that if your office sees less than 100 cases containing an encounter code in the measure denominator you do not have to participate in e-prescribe. Please call my office for any further information you may need.

5-11-2011 A bill introduced in the House last Wednesday and also supported by organized medicine, would let physicians set their fees for Medicare patients as high as the market will allow, balance bill them for the amount above Medicare's allowable charge and still remain in the program. The program titled Medicare Patient Empowerment Act, enables the freesetting and billing freedom by allowing physicians to privately contract with patients on what they will pay for medical services. You can only do this now as a physician if you drop out of the Medicare program altogether. This would help physicians make up for the paltry Medicare rates that deter them from treating seniors. This legislation will also insure that our seniors do not loose access to healthcare professionals and physicians, many of which are finding it harder to treat Medicare eligible patients. I will keep everyone posted on the news as I get it on this issue.

5-2-2011 To all my clients. MIFS is currently keeping a close watch out for flood waters. As of right now the levels behind Lowes on Germantown Parkway have subsided to 15 to 16 feet. Last Friday when the flooding was in our driveway they were at 26.6 feet. The EMA is keeping my downstairs neighbor up to date on all of this and if there is even a slight risk for flooding in my building we will be moving servers and other vital equipment and information to a different location. Periodic backups during the day are being maintained and I feel confident that we will have no interruption of service. Unless power goes out due to this we are working and if it does I have two very powerful generators that will be moved here to run the servers. Please call us with any questions or concerns.
4-22-2011 We are HIRING. Please submit resumes to 901-821-0384. Need experienced payments posters that understand medical line item posting and can read an explanation of benefits correctly. Also need patient account reps to follow up on claims.

2-24-2011 You will not have to worry about your Medicare payments falling by 30% or more until 2014 if a pay fix provision in President Obama’s proposed budget for fiscal 2012 is enacted. Your payments would see 0% updates in 2012 and 2013, paid for by $62 billion in savings the White House expects to get out of Medicare and Medicaid. Beyond this time the Administration is determined to work with Congress to put in place a long-term plan for reform.

2-10-2011 MIFS is open today. If you are an employee and did not make it in you can make up your time on Saturday if you choose to do so.

2-10-2011 As previously posted on 12-8-2010 The Center for Medicare & Medicaid (CMS) has announced a process to address inaccurate payments for some 2010 claims. Retroactive provisions in the Patient Protection and Affordable Care Act, coupled with technical corrections to the 2010 Medicare physician fee schedule, resulted in some overpayments and many underpayments on millions of Medicare fee-for-service claims during the first five months of 2010. To address this CMS announced it will begin reprocessing some of them over the next few weeks a process CMS says will take some time to complete. According to CMS claims will not be automatically reprocessed at higher rates. You must send in a request to have these reprocessed through the reopening area of their carriers company.

01-04-2011 Happy New Year everyone.

12-20-2010 Wishing everyone a Happy Holiday season and a wonderful New Year.

12-9-2010 Yesterday the Senate passed by unanimous consent, legislation preventing a 24.9% cut to Medicare physician payments. H.R. 4944 extends the current Medicare payment rates through Dec 31, 2011. The House is expected to act quickly on this as well. I will keep you posted on this as well as other issues pending with Congress.
12-8-2010  We would like to let everyone know that Cahaba Government Services is going to retro back claims to January 1, 2010 and pay the additional 2.3 percent that you are currently getting for your work. If you are a client of mine we will do this for you. If you are not a client contact my office for further details and I can let you know how we can guide you on this. This could potentially mean increased revenue for your practice so do not wait. The filing dead line for Medicare is now one year from date of service.

12-3-2010  A group called the National Commission on Fiscal Responsibility and Reform that was appointed by President Obama has proposed a plan titled "The Moment of Truth" that would freeze physician reimbursement rates through 2013 and then reduce the rates by 1% in 2014. After this period the commission report calls for a revamped formula for setting Medicare pay in 2015 that stresses care coordination and rewards providers for - quality not quantity- of their services. The formula would replace the SGR that will trigger the 25% cut next year unless Congress acts this month to avert it. I will try and keep everyone posted as I get news from the Centers of Medicare and Medicaid and other sources.

11-30-2010 Late yesterday afternoon the House passed a one month patch to the Medicare sustainable growth rate (SGR) formula. This bill will now freeze current physician rates through December 31, 2010. It temporarily halts the 23 percent cut to physician payments that were slated to take effect on December 1, 2010. The patch will be paid for by using 1 billion from a 20 percent cut in payments for outpatient therapy services. The bill will now remove those payments from the overall pool of money known as the PFS or physician fee schedule. Physicians and their staff need to continue to urge congress to call on Congress for an additional 12 month fix so that lawmakers can find a permanent fix to this ever present problem facing our physicians, the elderly and governmental workers.

11-18-2010 Late this evening the Senate approved by unanimous consent a bill that would provide a payment patch to the Medicare sustainable growth rate (SGR) formula. This is a 31 day fix only. This bill will hold the current rates for services provided through December 31, 2010 and temporarily avert a 23 percent cut to physician payments slated to take effect on December 1, 2010. The House had adjourned for the week and is expected to vote on the bill when they return. This is only a short term fix for what will be a national disaster if it is not put in place permanently. Many organizations are calling for a 12 month fix that will give lawmakers time to find a permanent solution to the matter.

11-10-2010 When federal lawmakers return to Washington the week of November 15 for a lame duck session, their first order of business will be to pass at most a month-long pay fix to get over the Dec 1 cuts that are expected. This is news from a industry lobbyist actively
involved in this process. This lobbyist states that they are going to pass something short-term to
get over the hump then later they are going to pass something during the lame duck session
that is a longer-term deal. Both parties agree that a 23% cut to physician payments is
unacceptable but will argue over how to pay for it. Please urge your congress men and women
to get a fix for this and make it a permanent one at that.

11-3-2010 Again I am urging all of you to contact members of congress and urge them to vote
against the Medicare cuts due to take effect on 12-1-2010 and again on 1-1-2011. Your groups
are facing a whopping 30.10 percent cut in Medicare reimbursement alone if this is not stopped.
That cuppled with the cuts to speciality groups and the doing away of the consultation charges
may mean that you will have to close your doors for good. Again, please urge everyone even
your Medicare patients to get on the phone and let Congress know that this is a disaster in the
making for our seniors and for the Medical profession as a whole. Know one will benefit from
this especially our aging population.

10-25-2010 Unless Congress intervenes, all physicians will face a 23.6 percent Medicare cut on
December 1, 2010. Additionally, another 6.5 percent cut that is scheduled for January 1, 2011
will take effect as well. Many practices are taking unheard of measures due to this. Many are
limiting the number of Medicare patients they are seeing or not taking these patients at all.
Practices are holding off purchasing new equipment due to the uncertainty that surrounds this
as well as holding off adopting EMR programs that are being forced on them. Please contact
your members of Congress and urge them to vote to end this and end it now. The impact this
is having on day to day operations is deplorable and what it is doing to Medicare recipients is
even worse. While physicians are being cut to the bone the pharmaceutical, insurance and
other sectors of Medicine are not being impacted. We urge you to take action now before its to
late.

10-18-2010 October 1, 2010 was deadline to make sure you 2011 ICD-9 file was updated with
the new and deleted codes. Check your practice management systems for this very important
issue.
10-13-2010 Upcoming elections will have a major impact on how and when the massive Medicare cuts could take place. Keep checking in with us to see all the news. I will post anything I hear as soon as I receive notification.

9-16-2010 Please call us for updated pricing on EMR licenses. Sage has updated their pricing for my office and we have some great discounts on provider licenses and programs right now. They also now offer a patient portal for meaningful use criteria that is really nice and that is necessary to acquire the incentive money being offered by the government. Please remember that even if you run a different EMR from the Sage Intergy Practice Management we can still help you with all your billing needs. An HL-7 interface is all that is needed to import information from one system to another. Call me with any questions you may have.

8-23-2010 I have received many calls from Administrators and Physicians in regards to the reimbursements that are currently being posted to your accounts. As you all recall The Center for Medicare Medicaid released money early in the last two weeks of July causing all of you to have record collections for the month. Because of the early release, money for August has been slow coming from Medicare and has effected your bottom line. Remember, money that should have been here in August came in late July. Please refer back to your letters I sent to you explaining this. If you have any other questions or need more clarification on this issue please call me. I want every one to be cautious with purchases and making decisions that could effect your practices operation for now. Please remember that again we will be faced with the possibility of the cuts that are on the agenda in Congress in late November. Every governing board of most major practice management firms are cautioning their clients not to make bold or rash moves until after the first of the year. I agree with this and am advising everyone to think long and hard about any changes that could effect your bottom line.

8-13-2010 Here we go again. Changes to the formats that we have to file claims with is set to implement on January 1, 2012. If you think you have time to waste, think again. The new Version 5010 for electronic claims submission is a good one but complicated. We have begun testing with Sage and our outlook is very promising. What this all means for you is that we will be ready when the start date rolls around. Version 5010 or Accredited Standards Committee (ASC) X12 for electronic claims submission is what all the hype is about. The new features include the following but are not limited to:

1) Field size adjustment for ICD codes  2) An additional didget will be added to separate ICD-10 from ICD-9  3) Spaces for diagnosis will increase. 4) Will elaborate between admitting diagnosis, patient reason for visit and presentation on admission conditions. 5) Uses very precise reporting elements called TR3 that will represent the data more clearly. 6)
These changes will greatly affect the way your charges are entered into a practice management system and reimbursement. Please make arrangements now to start reading and looking over what could greatly affect your bottom practice line in the near future.

8-12-2010 No new news from Cahaba which is good for all. Please keep in mind the hold for the first 2 weeks of August.

8-9-2010 Just a reminder that Cahaba is holding reimbursements for the first 2 weeks of August.

8-5-2010 I received lots of calls in regards to the 8-4-2010 post. Remember that the first 2 weeks of August there will be no Medicare disbursements due to the early release of money the last week of July. Please budget wisely.

8-4-2010 July posted record months for many of you but please keep in mind that due to the early release of money from Cahaba on your Medicare claims, your total overall collections were effected. That combined with the additional money paid for the cutbacks taken in May also made for record collections. I will keep you all posted on any new developments that may arise.

7-27-2010 Please look at the faxed notices I sent to all offices today concerning the release of checks early from Cahaba during the last days of July 2010. Please take note that due to the early release of these checks CMS has instructed the carriers to hold checks for the first 2 weeks of August thus causing another drop in income for you. Keep this in mind when budgeting for the end of July and August.

7-19-2010 We began receiving Medicare checks today with an adjustment for the 21.3% that was previously taken out of your reimbursements at the beginning of June 2010. These checks
also included the 2.2% raise you were given. We have gotten payments for dates of services through 6-25-2010 on some clinics. I will personally make sure that every claim is re-paid at the proper amount. I will post news as I get it each day.

7-13-2010 We are now receiving checks that have dates of service 6-1-2010 through 6-12-2010. The 2.2% increase continues to be attached. I have not seen any of the checks dated 6-29-2010 and 6-30-2010 being adjusted to date with cuts you all took or the raise. I will keep you all posted.

7-5-2010 As stated previously checks from Cahaba started coming in on June 29, 2010. All checks dated June 29, and June 30, 2010 had various cuts made to them. These cuts, again, ranged from 9.5% to 18.5%. Beginning on July 1, 2010 any checks we have received had the 2.2% increase on them. We will be watching this closely and I will keep you posted on this.

7-2-2010 To all my Providers. Checks cut for dates of service June 1 and forward began coming in on June 29, 2010. They did show cuts ranging from 9.5% to 18.5%. To date I have no answere for why as each rep you talk to at Cahaba Government Services tells a different story and cannot give me a straight answere. The checks cut yesterday on 7-1-2010 have the correct rates on dates of service June 1 and forward with the 2.2% raise. We are carefully watching all this and will keep everyone informed on this very important issue. Please call me for further information if you need to.

6-24-2010 This evening the House of Representatives passed the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (HR 3962) by a vote of 417 to 1. The legislation blocks the 21.3 percent cut to Medicare physician payments until November 30, 2010. The Senate passed similar legislation late last week. The President is expected to sign the bill into law shortly. Practices will then see the 2.2 percent increase in physician payments for claims with dates of service June 1, 2010 through November 30, 2010. I urge you all to write your congressman and women and encourage them to address this issue through the immediate repeal of the Medicare Substantial Growth Rate Formula.

6-17-2010 The Senate Democratic leaders introduced a substitute amendment to the HR 4213 bill that will include a provision for a 2.2 % increase to Medicare payments to physicians for claims dated June 1, 2010 to Nov 30, 2010. The House approved version of the bill failed yesterday. The Senate is expected to hold votes as early as today but this is little comfort for physicians facing a cut of this magnitude. The financial impact of this to our medical community
cannot be measured here. I will keep you all posted as I get information on this highly watched issue.

6-14-2010 Per CMS. CMS has now directed its contractors to continue holding June 1, 2010 claims and later through Thursday, June 17th, 2010, lifting the hold on Friday June 18th. This will greatly impact your practice cash flow so please make sure steps are in place to help you get through this period of time.

5-10-2010 Congress is considering a multiyear solution to the payment crisis our physicians are facing as early as next week. The massive cut will take effect on June 1, 2010 unless lawmakers act to avert it. Congressional democrats appear ready to enact a longer term solution to Medicare reimbursement that may even include a raise for physicians. Organized medicine has lobbied Congress for a permanent fix, namely a repeal of the sustainable growth rate (SGR) formula that Medicare uses to calculate physician pay. I will keep everyone posted as to what is happening up on Capital Hill.

4-30-2010 Uploads from Cahaba are starting to show April payments. Good News For All.

4-28-2010. Please call our office for a copy of the recent live webinar from MGMA outlining the Healthcare Reform Law/ The Patient and Affordable Care Act Reference Implementation Timeline. It outlines many topics that we are all interested in and clearly defines what is in store for all of us. Call Marlene today for a copy.

Click here for more information from the Centers for Medicare and Medicaid.

Welcome to Medical Insurance Filing Services, Inc. Our group is centered around one fundamental objective: increasing physician income. Our experienced staff is dedicated to
efficient provision of services through people, products, and knowledge. We customize medical billing plans on the specific needs of each practice.

Our business model allows you to save time, keep staff overhead to a minimum, reduce account receivable time-lines, improve leverage with insurance carriers, and reduce claim rejections.

We offer complimentary, no-obligation consultations to analyze your individual practice. Please call us at (901) 821-0338 or email mwright@medbillinc.com to schedule your consultation.