The Federal Government has significant impact on the health care delivery system, through the Department of Health & Human Services, the Center for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), along with the actions of the United States Congress. This course will detail many of the key changes made in the Medicare program for 2006, including: Discussions of the Physician Fee Schedule; Changes to RVU and Geographic Practice Cost Indices; Changes to Medicare Part B and the new Part D Prescription Drug Program; Updates to the STARK rules; a Legislative Update in addition to a wide variety of other important and timely topics. This course will be valuable for all physicians, surgeons, office managers, supervisors and staff.

This Practice Management Teleconference is just $99 for ACS Fellows & their Practices:

- A 90-minute live teleconference including a formal presentation and time for Q&A
- The course is given once as a live teleconference, on Wednesday February 15, 2006 (convenient for your staff) and then via streaming Internet technologies shortly thereafter. Your $99 registration fee covers either one or both presentations and handout materials.
- The ability for ACS Fellows and practice managers to e-mail follow-up questions to Economedix Practice Management Advisors for personalized responses

Course Objectives - Completion of this Practice Management Course will provide:

1. An update on the status of Congressional actions regarding the Physician Fee Schedule
2. Details regarding changes to Medicare’s RVU, GPCI and the Conversion Factor
3. Updates on other changes to the Medicare Part D and STARK programs
4. A detailed review of the new Medicare Part D program for Prescription Drug Coverage for Seniors
5. A broad review of other Federal related programs of vital interest to physician and surgical practices

Accreditation - The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education to physicians.

CME Credit - The American College of Surgeons designates this educational activity for a maximum of 1.5 category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity. To earn the CME credit, participants must complete the combination Evaluation / CME Form, that is included in the course materials, and FAX this form back within seven days following the date of the teleconference.

Faculty - The faculty for the course is Mr. Tom Loughrey, MBA, CCS-P. Mr. Loughrey is CEO of Economedix and a noted practice management consultant to physicians, medical offices and medical societies. For over a decade, Mr. Loughrey has provided consulting services to the College as a part of the Consultant’s Corner at the annual ACS Clinical Congress and regularly is engaged by ACS to speak and teach at meetings and workshops throughout the country.

Registration & Information - This completed form can be Faxed Toll Free to 877-813-9784; or mailed to Economedix - 297 Valley Road # 200 - Wexford, PA 15090; For complete details and secure On-Line Registration simply go to: http://YourMedPractice.com/ACS

Thank you for your interest in this Program!
American College of Surgeons
EVALUATION / CME FORM

NAME: _____________________________________________ Telephone #: ______________________
ACS Fellow #: _______________________ E-mail Address: ______________________________________

Please circle one number for each statement

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<th>Neutral</th>
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1. Program topics and content were consistent with printed objectives

2. Program topics and content was relevant to my educational needs

3. Presenters were informative and added knowledge to the session

4. Discussion time was adequate and enhanced understanding of subject

5. Acquired knowledge will be applied in my practice environment

6. Supplemental written materials helped clarify course content

7. I will seek additional information on this subject

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<th>Poor</th>
<th>Very Poor</th>
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8. The quality of the audio presentation was

9. Overall this Practice Management Course was

General Comments for this Course:

Surgical Specialty

<table>
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<th>Years out of Residency Training</th>
<th>Primary Type of Practice</th>
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<tr>
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<td>[ ] Other - Please Specify Below:</td>
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Please FAX this Evaluation / CME Form Toll Free to: 877-813-9784 within 7 days following this Teleconference to receive CME recognition from the American College of Surgeons. Thank You!
Sign In Sheet

Educational Activity: Medicare Update 2006

Dates: Wednesday, February 15, 2006 @ 3:00 PM Eastern

Faculty: R. Thomas (Tom) Loughrey, MBA, CCS-P of Economedix, LLC

Sponsor: The American College of Surgeons

1. _______________________________________________ ____________________

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Your Partner In Building High Performance Practices

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Today’s Presentation

Medicare Update 2006

Practical Information for Physicians
and Office Staff on the Latest
Changes from Medicare

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Handout Materials

Click Here for the Course Overview … (PDF File)

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Course Faculty

R. Thomas (Tom) Loughrey, MBA, CCS-P
• Chairman, CEO & Co-Founder of Economedix
• Certified Coding Specialist
• BS Degree from Pennsylvania State University
• Earned an MBA in Health & Hospital Administration from the University of Florida
• Former Hospital Administrator
• Former Owner of a Medical Billing Company
• Consultant to Physician Practices & Medical Societies
• Member of Various Professional Organizations Dealing with Medical Practice Management
• Developed and Presented Thousands of Seminars & Workshops Dealing with Practice Management

ACCME Disclosure

R. Thomas (Tom) Loughrey, MBA, CCS-P
In accordance with the policies on disclosure of the Accreditation Council for Continuing Medical Education, presenters for this program, except for any noted below, have identified no personal relationships with a health care product company which, in the context of their topics, could be perceived as a real or apparent conflict of interest.

No conflicts were disclosed

Today’s Course

• Medicare Background
• 2006 Physician Fee Schedule
• Specific Policy Changes
• Drug Issues
• Imaging
• Demonstration Projects
• Stark & Physician Self-referral
Medicare Background

- Medicare is a federally funded and beneficiary funded health care plan
- Total program costs for all providers will be over $350,000,000,000 in 2006.
- Part B covers physicians and is optional for beneficiaries
- Medicare has been in existence since July 1965

The first Medicare Card application was issued to President Harry Truman by President Lyndon Johnson when he authorized the Medicare program in 1965

Medicare Background

- 17,735,966 - # of Medicare Beneficiaries in 1966
- 37,039,848 - # of Medicare Beneficiaries in 2000
- 77,200,000 - # of Medicare Beneficiaries expected in 2030
- $3.3 Billion - Amount spent on Medicare in 1966
- $300 Billion - Amount spent on Medicare in 2005
- $698 Billion - Amount to be spent on Medicare by 2014
**Medicare Premiums**

- Part B - $88.50 per month ($78.20 last year) usually taken out of the Social Security payment
- Part A - No premium for qualified enrollees
  - $393 for those who are not otherwise eligible (less than 30 quarters of covered employment)
  - $216 for those not otherwise covered and have 30-39 quarters of covered employment


**Medicare Deductibles and Co-payments**

- Part B - $124 per year. 20% of allowed amounts for covered services. 100% for lab.
- Part A –
  - Deductible: $952 per benefit period
  - Coinsurance: $238 for the 61st – 90th day of each benefit period and $476 per day for the 91st through the 150th day (these are the 60 lifetime days)

**2006 Fee Schedule**

- Fee schedule calculation: No Change
- Work RVU X Work GPCI plus
- Practice Expense RVU X PE GPCI plus
- Malpractice RVUs X Malpractice GPCI

Equals: Total RVUs

Total RVUs X Conversion Factor Equals Allowed Amount
2006 Fee Schedule

Conversion Factor For 2006

$37.8975

The conversion factor is unchanged from last year. Prior to action on 2/1/06 by Congress the conversion factor was $36.177

Example: 19120 Remove Breast lesion

Geographic Practice Cost Indice: Atlanta, GA

<table>
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<tr>
<th>Units</th>
<th>Work</th>
<th>Practice Expense</th>
<th>Malpractice</th>
<th>Total</th>
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<td></td>
<td>5.55</td>
<td>4.55</td>
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<td>GPCI</td>
<td>1.010</td>
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<td>4.95495</td>
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Conversion Factor $37.8975 \times 11.26563 = $426.94

If procedure is done out-of-office the Practice Expense Units change

<table>
<thead>
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<th>Units</th>
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<th>Practice Expense</th>
<th>Malpractice</th>
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<td>.70518</td>
<td>9.65391</td>
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Conversion Factor $37.8975 \times 9.65391 = $365.86
Fee drops by $61.08
Trends In Unit Values

<table>
<thead>
<tr>
<th>Code</th>
<th>Brief Description</th>
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<th>2002 Units</th>
<th>2004 Units</th>
<th>2006 Units</th>
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<td>Chest X-ray</td>
<td>.96</td>
<td>.95</td>
<td>.93</td>
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<td>99213</td>
<td>Office Visit</td>
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<td>1.32</td>
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<td>Hospital Visit</td>
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<td>33519</td>
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<td>10.39</td>
<td>10.51</td>
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<td>19101</td>
<td>Breast Biopsy</td>
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<td>8.24</td>
<td>8.66</td>
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Using The 2006 Medicare Fee Schedule

- Use the Excel Spreadsheet included with this course
- Medicare provides information on the details of when and if they will make payments
- Allows the user to know in advance exactly how a claim will be processed
Medicare Physician Fee Schedule Notes

- The PFS spreadsheet has columns indicating conditions and exceptions for payment. Among the most important are:
  - Status: Does Medicare pay for the service at all?
  - Global days, pre-op, intra-op and post-op percentages
  - Multiple and Bilateral procedures: approved or not?
  - Assistant, co-surgeon and team surgery: approved or not?

Specific Changes to the Fee Schedule

- The anesthesia conversion factor is $15.75 to $19.43 based on locale. Averages $16.9591
- CMS will apply savings from implementation of certain multiple procedure discounts to certain imaging services. This does not effect most surgical procedures.
- Practice Expense levels for 2006 will be based on 2005 levels with few exceptions.
Sustainable Growth Rate

- SGR Formula based on:
  - Projected growth rate in gross domestic product (GDP) per capita
  - Number of beneficiaries in fee-for-service medicare
  - Percentage changes in fees for physician services
  - Costs to the Medicare program due to changes in laws and regulations

Currently:
- The cost of Part B drugs are to be included in the definition of “physician services” and thus are included in the SGR calculation
- Most physician organizations continue to argue that drugs are not a service and should not be included in the calculation.
- Professional societies and members of Congress have said CMS can fix this without a legislative action. CMS thinks only congress can make the change.

What’s ahead
- Was to be a 4.4% cut in 2006 but changed by act of Congress
- 5% cut in 2007 and every year thereafter
Policy Changes

- Intro to Medicare Reimbursement
  - CMS must publish a list of payment rates for services covered by Medicare and policy changes
  - Published in the Federal Register as "Medicare Physician Fee Schedule"
  - Proposed in August
  - Final rule issued after November 1
  - Available at: www.cms.hhs.gov/physicians/pfs/CMS-1502-FC.pdf

Preventive Health Benefits

- ESRD Facilities
  - Exceptions to payment rates are limited to pediatric ESRD facilities
  - Defined as facility in which 50% or more of patients are age 18 or under
  - Facilities may apply for exceptions after one year of operation
  - Non-pediatric facilities that have an exception from before 12/1/2000 may keep the exception

Policy Changes

- ESRD Facilities
  - Wage index will adjust for geographic differences
  - Rule adopts a new urban/rural designation for the wage index to be phased in over 4 years
  - Wage index ceiling will be eliminated as of 2006
  - Wage index floor will be lowered over two years and then eliminated altogether
Policy Changes

- Federally Qualified Health Centers
  - FQHCs may enter into contractual arrangements with Medicare Advantage Plans
  - Payments under these contracts may be less than it would under Medicare FQHC payment rates
  - If this occurs the Medicare Modernization Act (MMA) requires supplemental funds for FQHCs for an amount equal to the difference
  - Payments made on a fee-for-service basis for an encounter with a core practitioner (physician, PA, CNP, CNM, clinical psychologist, clinical social worker)

Policy Changes

- Glaucoma Screening
  - In 2002 Medicare began paying for glaucoma screening for:
    - Individuals with diabetes
    - Individuals with family hx of glaucoma
    - African Americans age 50+
  - New rule adds Hispanic individuals over age 65

Policy Changes

- Therapy Caps
  - Balanced Budget Act of 1997 imposed caps on O/P therapy services
    - PT, OT and speech-language
  - Statutory moratorium on caps expired 12/31/2005
  - Annual cap will be $1,740 for each category
  - House and Senate do not yet have agreement on a moratorium for the caps
Policy Changes

Scarcity Area Payments
- Under MMA physicians will automatically receive a bonus based on the zip code of the site of service and paid quarterly
- Bonus differs for primary care and specialists. OB/Gyn is classified as primary care
- Not available to dentists, chiropractors, optometrists and all non-physician providers
- Services not eligible:
  - Technical component, incident to services & therapy
  - Eligible services must be billed separately between professional & technical components

CMS maintains a list of zip codes eligible for the bonus payments at:
http://www.cms.hhs.gov/providers/bonuspayment/

- The lists identify areas that will automatically be given a 5% payment
- Providers should use modifier - AR for claims identification eligibility
- Anesthesia services must use - AR to be paid

Health Professional Shortage Areas
- To be eligible, services must be provided within the physical boundaries of a primary care or mental health HPSA
- Applies to primary care, dentists and psychiatrists
- 10% bonus payment
- Starting in 2006 eligible providers will automatically receive the bonus
- Providers in identified zip codes should use modifier –QB for rural HPSA and –QU for urban HPSA
Drug Policy Changes

- MMA changed Part B drug reimbursement
  - Prior to 2004: 95% of Avg. Wholesale Price
  - 2004: 85% of AWP
  - 2005: Avg. Sales Price plus 6%
  - 2006 ASP plus 6% or Competitive Acquisition Program (CAP)
  - CMS acknowledges some physicians may not be able to purchase drugs at ASP plus 6%.

Drug Policy Changes

- IV Immune Globulin (IVIG)
  - Difficult because of market instability
  - In 2006 CMS will pay an additional payment of $10
  - Use G0332, billable once per day per patient
  - Can bill separate E&M service on same day with modifier -25

Drug Policy Changes

- ESRD facilities
  - ESRD facilities will get a drug add-on adjustment of 14.7%
  - The top ten ESRD drugs furnished by facilities will be reimbursed at ASP plus 6%
Drug Policy Changes

Inhalation Drugs
- Dispensing fee for inhalation drugs provided by nebulizer:
  - First use (30 day supply): $57
  - All other months: $33
  - 90 day supply: $66
- Fee reduced because educational portion of payment is not billable and education not being performed anyway

Drug Policy Changes

Medicare Part D
- Single largest expansion of the Medicare program since its inception
- Law was largely crafted by Pharmaceutical companies
- Initial experience shows significant confusion and loss of coverage for Medi/Medi patients

Imaging Policy Changes

- Imaging is fastest growing component of Medicare program
- Reduced payment for Technical component when additional procedures are performed during same encounter and on same body parts within the same family of services
- TC reduced 25% in 2006 and 50% in 2007
- Multiple encounters each day paid in full within same family if documented need and -59 modifier used.
Imaging Policy Changes

- Imaging Families
  - Ultrasound (chest, abdomen/pelvis – non-obstetrical)
  - CT and CTA (chest/thorax/Abd/pelvis)
  - CT and CTA (head/brain/orbit/maxillofacial/neck)
  - MRI and MRA (chest/Abd/Pelvis)
  - MRI and MRA (Head/brain/neck)

- Imaging Families -continued
  - MRI and MRA – spine
  - CT – spine
  - MRI and MRA – lower extremities
  - CT and CTA – lower extremities
  - MR and MRI (upper extremities and joints)
  - CT and CTA (upper extremities)

Imaging Exclusions
- Payment not implemented for:
  - Transvaginal ultrasounds
  - Ultrasound of breasts
- CMS will continue to study these to determine whether or not to include these two procedures
Oncology Demonstration Project

- Available to Hematologists and oncologists
- CMS is seeking to obtain additional information about coordination of care, treatment design and patient monitoring
- 2006 - $23 payment for each eligible visit – patient has 20% co-payment
- Tied to E&M visits
- Bill G code (G0101 et al) depending on type of exam

Eligible Cancers

- Breast cancer
- Colon cancer
- Rectal cancer
- Prostate cancer
- Lung cancer
- Stomach cancer
- Head and neck cancer
- Esophageal cancer
- Pancreatic cancer
- Ovarian cancer
- Non-Hodgkins Lymphoma
- Chronic myelogenous leukemia
- Multiple myeloma

Stark & Physician Self-Referral

- Physicians are prohibited from referring patients for certain Designated health Services if the physician has a financial relationship with the entity.
- Usually referred to as Stark (named for Congressman Fortney Stark)
Stark & Physician Self-Referral Designated Services

- Clinic lab
- Physical therapy
- Occupational therapy
- Radiology and certain other imaging
- Radiation therapy
- DME
- Home Health
- Parenteral & Enteral Nutrition
- Prosthetics, orthotics and supplies
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Stark & Physician Self-Referral Code Update

- CMS updates the list of CPT and HCPCS codes included in the Designated Services
- This list covers five of the eleven categories of Designated Services
- 2006 has 20 additions and 15 deletions
- The complete list can be found at: http://www.cms.hhs.gov/apps/ama/license.asp?file=/medlearnproducts/downloads/011006finalcodelist.zip
  We have included it with the RBRVS spreadsheet

CCI Edits

- Medicare no longer requires you to buy the CCI edits
- The CCI Edits Manual may be obtained in two ways. The first is through the CMS website at http://www.cms.hhs.gov/physicians/cciedits/default.asp.
- CCI Edits Manual may be obtained by purchasing the manual, or sections of the manual, from the National Technical Information Service (NTIS) website at http://www.ntis.gov/products/families/cci, or by contacting NTIS at 1-800-363-2068 or 703-605-6060.
Local Medicare Review Policies

- LMRPs are created by each carrier which describe how various payment and determination issues are dealt with
- Contact your local carrier for information on obtaining a current list of LMRPs
- May be available at a carrier website or from carrier newsletters and updates

What’s Coming?

- Congressional reconciliation of payment cuts – Occurred 2/1/06
- Will Congress change how the payment formula is calculated for a permanent fix?
- What will be the impact of Medicare Part D

Summary

- Medicare is constantly changing
- Pay close attention to communications from your carrier
- Log onto the Medicare site at [www.cms.gov](http://www.cms.gov) on a regular basis for new information
- Sign up for Economedix’ free Tips & Techniques @ YourMedPractice.com
Questions & Comments

If you have specific questions CLICK HERE to ASK TOM

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Thank you for participating in this seminar presentation from Economedix!

Please direct questions to ...

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