Philadelphia Medicine

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The annual "Doc Fix"— a symptom of a systemic problem

By Lynn Lucas-Fehm, MD, JD

The pressure is on again to obtain the so-called "doc fix" for physicians who treat Medicare's millions of beneficiaries. Billions of dollars are needed to avoid rate cuts as determined by the SGR formula.

The SGR or Sustainable Growth Rate is determined by many factors including but not limited to:

- Estimated change in fees for physicians' services.
- Estimated change in beneficiaries enrolled in Medicare's fee-for-service program.
- Estimated growth in gross domestic product (GDP) per capita.
- Estimated change in expenditures due to law and regulation.

> As frustrating as this yearly cliffhanger has become, the true calamity is the inability to effectively negotiate a permanent solution.

In an October 14 letter to lawmakers, the Medicare Payment Advisory Commission (MedPAC), which advises lawmakers on Medicare payments, called the formula "fundamentally flawed" and said it "has failed to restrain volume growth and, in fact, may have exacerbated it."

MedPAC recommended eliminating the formula without increasing the deficit by cutting fees for specialists and imposing a 10-year freeze on rates for primary care physicians. That proposal was strongly opposed by health industry groups, as well as the American Medical Association (AMA).

Despite the fact that the formula is clearly flawed, the SGR continues because Congress can't agree on where to obtain the funds needed to eliminate it. One estimate notes that the amount needed to retire the "doc fix" issue is $300 billion over the next decade. The House recently passed legislation including a "doc fix " provision but it faces significant challenge in the Senate.

Medicare pay cut averted: Congress OKs two-month patch

Physicians got a brief reprieve from a 27% Medicare pay cut when the House of Representatives reached agreement with the Senate on a two-month extension of important policies that would have expired on January 1. The Senate voted to extend current Medicare payment rates for two months.

As frustrating as this yearly cliffhanger has become, the true calamity is the inability to effectively negotiate a permanent solution.

The yearly SGR debate is just a symptom of the systemic disease of Washington gridlock.

There needs to be a political resolution of the SGR problem, one which incorporates physician practices to play a substantive role in managing healthcare costs and directly addressing the causes of inflation in the present Medicare program. Reforming malpractice and improving how we care for the sickest 5% of Medicare's patients are factors that must be addressed if this annual dilemma is to be resolved.

Our biggest obstacle is the political process and unfortunately the potential for any meaningful resolution will likely have to wait until after the elections in the fall of 2012.

Dr. Lucas-Fehm is President of PCMS

PCMS NEWS

PCMS Upcoming Events

Programs are held PCMS headquarters unless otherwise noted.
You must register to attend all programs:
215-563-5343, Ext. 113

All PCMS Members
"CME Osteoporosis Program"
Speaker: Alan Epstein, MD, Rheumatology and Internal Medicine Specialist
Tuesday, February 28, 6:00 - 8:00 PM
No fee to attend

Practice Managers
"Contracting Pitfalls," and ICD 10 Update
Wednesday, March 7, 2012, 11:30 AM - 1:30 PM
Luncheon meeting
No fee to attend.

Residents and Fellows
"Understanding Your Employment Contract: A Legal Review"
Speaker: Daniel Shay, Esquire
Thursday, March 8, 6:00 - 8:00 PM
No fee to attend

All PCMS Members
"CME COPD Program"
Speaker: Frank Leone, MD, MS, Director Comprehensive Smoking Treatment Program, University of Pennsylvania
Tuesday, March 20, 6:00 - 8:00 PM
No fee to attend

All PCMS Members
"Change, Challenge & Opportunity — The 2012 Tools for Success Medical Practice Management Conference"
Thursday, April 19, 2012, 7:45 AM - 4:00 PM
Location: The Villanova Conference Center
For information, please phone 610-892-7750

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HEALTHCARE MEDIA INTERNATIONAL

Editorial

The evolution of organized medicine, [part 2]

By Lynn M. Lucas-Fehm, MD, JD

In January, Philadelphia Medicine *published Part 1 of the Evolution of Organized Medicine by Dr. Lucas-Fehm. This is part 2 of that article.*

By the 1920's, the higher cost of medical care became an issue, especially for the middle class. With the Depression in the 1930s there was greater emphasis on unemployment insurance and "old age" benefits. The Social Security Bill was debated and the AMA actively lobbied against including healthcare in the SSA. When the Social Security Act finally passed, health insurance was omitted. At the same time, Blue Cross began offering private coverage for hospital care in dozens of states.

> As the government and private sector took more control of medical care, medicine became more fragmented. AMA membership exceeded 200,000 in the 60s with the number of doctors reporting themselves as full-time specialists growing from 55% in 1960 to 69% by the end of the decade.

In the 1940s, a decade remembered by many as the first time that penicillin was widely used, prepaid group healthcare began as competition for workers motivated companies to offer health benefits. This was the beginning of the employer-based system in place today.

The debate over social insurance was reborn when President Truman offered a national health program plan, proposing a single system that would include all of American society. It was not widely supported in Congress. The AMA responded by opening an office in Washington, DC, and launching a campaign against President Truman's plan.

At the start of the 1950s, national healthcare expenditures constituted 4.5% of the Gross National Product. America developed a system of private insurance for those who could afford it and welfare services for the poor. The debate about the need for socialized medicine increased nationwide.

One of the more notable public relations initiatives that the AMA developed during this debate was entitled "Operation Coffee Cup." This campaign was conducted during the late 1950s and early 1960s in opposition to plans to extend Social Security to include health insurance for the elderly (which later became Medicare). As part of the public relations campaign, doctors' wives would organize coffee meetings in an attempt to convince acquaintances to write letters to Congress opposing the program. The operation received support from Ronald Reagan, who in 1961 produced the LP record *Ronald Reagan Speaks out against Socialized Medicine* for the AMA. This record was played at the coffee meetings.

By the 1960s, those outside the workplace, especially the elderly, had difficulty affording insurance despite the presence of over 700 insurance companies selling health coverage. In response, Congress passed and President Lyndon Johnson signed Medicare and Medicaid into law.

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In the years following the enactment of Medicare, healthcare costs escalated, rapid inflation occurred, and changes in medical care, including greater use of technology and medications, led to the growing realization that American medicine was in crisis.

President Richard Nixon renamed prepaid group healthcare plans as health maintenance organizations (HMOs), with legislation that provided federal endorsement, certification, and assistance in the 1970's.

Corporations began to integrate the hospital system (previously a decentralized structure) in the 1980s. Companies entered many other healthcare-related businesses and consolidated control. Overall, there was a shift toward privatization and corporatization of healthcare.

Under President Reagan, Medicare shifted to payment by diagnosis (DRG) instead of by treatment. Private plans quickly followed suit. "Capitation" payments to doctors became more common.

Part 3 of this editorial will appear in a subsequent issue of Philadelphia Medicine.

What you need to know to help prevent ambulance fraud

The City of Philadelphia and surrounding counties have seen a dramatic increase in the number of ambulance providers. From 2006 to 2011, Montgomery and Philadelphia counties have had a 73% increase in the number of Medicare credentialed ambulance providers performing services.

Data show that the state of Pennsylvania has more ambulance providers than both the states of New York and New Jersey combined; 84% of Medicare paid dialysis transports in the state of Pennsylvania originate from one of five counties in the Philadelphia region.

The Medicare Ambulance Benefit is very restricted and allows for payment only under limited circumstances. Physicians who order an ambulance and/or certify the medical necessity for their patients need to be aware of these limitations.

The Medicare Ambulance Benefit is very restricted and allows for payment only under limited circumstances.

Medicare covers ambulance services only if furnished to a beneficiary whose medical condition at the time of transport is such that transportation by other means would endanger the patient's health. A patient whose condition permits transport in any type of vehicle other than an ambulance does not qualify for Medicare payment of the ambulance benefit.

It is critical that physicians who complete medical necessity forms for ambulance transports understand their role. The mere presence of a completed, signed and dated medical necessity form by a physician does not automatically qualify a patient for ambulance transport. If it is determined that a patient can be safely transported by other means, Medicare will not pay for the trip.

The problem with fraudulent billing of ambulance transports is most evident in the billing for routine transports for dialysis services. Physicians need to be alert to requests they may receive asking them to certify the need for these ambulance transports.

Unscrupulous ambulance companies have been known to offer kickbacks to physicians who agree to sign Physician Certifications for Ambulance Transports. These ambulance providers may solicit the beneficiary's treating physician or physicians who have little or known history with the patient.

Zoning change will affect opening a new medical practice in Philadelphia

At the end of 2011, Philadelphia City Council approved legislation which adopted a new zoning code that was signed into law by the Mayor. The code incorporates significant revisions to how new development and the use of property will proceed in the city of Philadelphia.

The new zoning code, for the first time, regulates solo medical practitioners differently than group medical practitioners. There was concern in City Council that some types of medical practices are not wanted in some neighborhoods. As a result, the new zoning code makes it more difficult to open and operate both a solo home medical practice and a larger group practice.

Solo practitioners operating out of a home office will now be limited to

Continued on page 4

QIPS program changes for measurement year 2012

Late last year, a letter was mailed to participating primary care practices from IBX advising them of changes being made to the Quality Incentive Payment System (QIPS) program for measurement year 2012.

For complete details of the QIPS program, refer to the QIPS Program Manual "Measurement Year 2012" which is now available through the NaviNet® web portal.

If you have any questions about these program changes, contact IBX Customer Service at 1-800-ASK-BLUE.

Restrictions on medical records copying charges for 2012

General Rules

Source of request	Copying (per page)		Retrieval	Postage, shipping, and delivery
Patient	Paper Pages 1-20 Pages 21-60 Pages 61+ Microfilm	 $1.39 $1.03 $0.34 $2.04	Prohibited by HIPAA privacy rule	Actual cost
Personal representative, such as parent of minor	Same as limits for patients		Prohibited by HIPAA privacy rule	Actual cost
Designee of patient, such as attorney with authorization	Same as limits for patients		$20.62	Actual cost

Special Purpose Requests

To support	Copying	Retrieval	Postage, shipping, and delivery
Social Security claim or appeal	$26.12 flat rate	No additional charge permitted	Actual cost
Federal or state needs-based benefit program	$26.12 flat rate	No additional charge permitted	Actual cost

The physician may require the requester to provide documentation of the purpose of the request, such as an appointment of representative form SSA-1 696-U4) when the patient's attorney makes the request for a Social Security claim or appeal.

Third party requests

Source of request	Copying	Retrieval	Postage, shipping, and delivery
Subpoena (except as below)	Same as limits for patients	$20.62	No additional charge permitted
Subpoena from district attorney	$20.62	No additional charge permitted	No additional charge permitted
Commonwealth agency (executive or independent), such as licensing board	Allowed only if required by law or authorized by agency guidelines, statements of policy, or notice in Pennsylvania Bulletin		

pcms people

Zoning change, from page 3

one staff person and one parking space, which will make doing business nearly impossible, and there are new restrictions as to where they can be located.

Further, group medical practices are also newly restricted and will have to seek permission of the Zoning Board in order to open and operate on most of the city's commercial corridors.

Enactment of these proposals will have the unintended consequence of making it more difficult and expensive to establish community based medical practices in Philadelphia. In addition, these proposals could dissuade physicians from establishing new medical offices in the City and could result in physicians leaving the area.

Over the next few months, PCMS will be developing a coalition of healthcare partners interested in amending and better defining this section of the zoning code so that all the needs are served and that patient medical access is not adversely impacted. If you are interested in getting involved, please contact the PCMS office at 215-563-5343. Stay tuned.

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