

# WASHINGTON REPORT - MARCH / APRIL ISSUE

## A Government Relations Publication

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### **The Patient Protection and Affordable Care Act**

After more than a year of contentious and vigorous debate, and months of wrangling, deal-making and arm-twisting, the President received and signed into law the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010. As Vice President Joe Biden famously (or infamously) said at the bill signing ceremony over an open mike "This is a big F\*\*\*ing deal!".

A summary of the legislation appears on the HBMA website under the "members only" section. You are encouraged to download a copy of the summary. Please note that it does not cover every section of the bill, but what we believe are the provisions of greatest interest to the HBMA membership. In addition, since the summary was written, we have discovered many new provisions that were hidden or "buried" in the bill. We will periodically update the summary as more details as they become available.

One example of a "hidden" provision has to do with a group called the Practicing Physician's Advisory Council (PPAC). The Council was created by an Act of Congress several years ago to create a formalized process by which physicians could meet periodically with CMS officials to give them the perspective of "practicing physicians". As a result of one single sentence in the 2,000 page bill, this Council is now out of existence (see story below on PPAC).

This is just one example of dozens of changes that are hidden in the healthcare reform legislation that have garnered little, if any, public attention. For example, how many readers of this article were aware that due to the PPACA, every employer in America (unless the employer can demonstrate hardship) will be required to provide a room away from other employees or customers, and reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth, each time such employee has need to express the milk? Whether people agree with this provision or not, the point is, how many people were even aware that this was in the Patient Protection and Affordable Care Act?

The summary of the PPACA available on the HBMA website is approximately 23 pages long. Here is a link to a copy of the Patient Protection and Affordable Care Act ([PPACA](#)), as well as the Reconciliation Amendments ([Reconciliation Amendments](#)) that modified the PPACA. As you may have heard during the debate, the PPACA was more than 2,400 pages long when it was finally passed by the Senate. Yet when you go to link above, you will notice that the PPACA is “only” 906 pages.

The reason the final version is “smaller” is that when the Government Printing Office produced the final version of the bill it used a dramatically smaller font size than the working versions used by Congress. Smaller font size allows more words to appear on a page and the end result is fewer pages. Smaller fonts and fewer pages means less ink and less paper and therefore less cost to produce a hardcopy of the new law.

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## **HCR – The Bill is Passed, Now What?**

Now that the Patient Protection and Affordable Care Act (PPACA) has been signed into law, many are wondering, what's next? Unfortunately, we are now about to enter into what will be the scariest and most unpredictable aspect of the effort to reform our nation's healthcare delivery system – rulemaking.

Unlike the process of writing legislation that is – in theory – open, rulemaking is the ultimate black box of the policy making milieu. In general, all proposed federal rules must be published and generally made available to the public for comment for 45 to 60 days. These are called Notices of Proposed Rulemaking or NPRM. Once the 45 – 60 day public comment period ends, the rulemakers enter a secretive phase of the process that would make the College of Cardinals during the selection of a new Pope envious.

At least with the College of Cardinals, you see a plume of white or black smoke out of a chimney at the end of each day signaling whether the Cardinals had reached a consensus. With rulemaking, the “review” process can take upwards of three years to complete, and the agency need only acknowledge the comments they received but need not provide any rationale or justification for adopting a policy that may be counter to the overwhelming majority of comments received.

Beginning this year, we anticipate that the Department of Health and Human Services (HHS) will begin issuing rules and regulations implementing various provisions of the Patient Protection and Affordable Care Act. In some cases, the regulations will be issued in “proposed” form but in other cases where there is a rapidly approaching deadline, the agency will issue what is referred to as either an “Interim Final Rule” or “Final Rule with Comment”.

NPRMs are published in the *Federal Register* and describe what the agency is proposing with regard to a particular issue or policy area. NPRMs associated with healthcare reform will typically be hundreds of pages in length and will cover a myriad of topics. The public will be afforded an opportunity to review the proposals and provide comments to the agency for their consideration.

At some point after the close of a public comment period, the agency will issue a “Final Rule” which will be published in the Federal Register. If CMS fails to act on a proposed rule within three years of the issuance of the NPRM, the agency must withdraw the proposed rule.

Interim Final Rules or Final Rules with Comments are different. In each of these cases, HHS is issuing a final rule without benefit of public comments but affording the public an “after the fact” opportunity to tell the government what it thinks of the new rule. There is no guarantee that anyone in the government will actually

review or consider the after-the-fact comments (remember, this is already being issued as a final rule), but you at least have the comfort of knowing that someone in the government at least asked you for your opinion.

In the case of the PPACA, we will likely have a little of all three types of rulemaking, as well as a fourth process – negotiated rulemaking.

For the PPACA, the rulemaking process will be even more difficult than normal because there are no “Committee” or “Conference” reports to guide the agencies.

Why is this a problem?

During the normal legislative process, when a Committee recommends adoption of a piece of legislation, the Committee generally issues a report that explains the thinking and rationale behind the changes that are being recommended. This is referred to as a – Committee Report – OK, no one said Congress was creative when it comes to this stuff.

Similarly, when the House and Senate meet in a Conference Committee to resolve differences between their respective versions of legislation, they issue what is referred to as a – Conference Report (the creative juices were really flowing...). A typical Conference Report is a helpful road map describing the final outcome of the House-Senate negotiations because the document will first note “current law” then summarize the proposed House change as well as the proposed Senate change and finally, the agreed upon language. Most important, this Conference Report is written in plain English rather than legalese.

All of these Reports are extremely critical when it comes to the rulemaking process because they help the Judicial Branch discern what is referred to as “Congressional Intent”: What did Congress mean by enacting certain changes? It is not uncommon that throughout legislation there will be words or phrases whose meaning could be interpreted differently by different people.

Now, think of the phrase “health care provider”.

To many, this phrase is fairly easily understood. When you read it, you almost immediately create a mental image of a healthcare professional, perhaps a physician. But is it really? Who (or what) is a health care provider? Is it a hospital, nursing home, home health agency, physician, PA, NP, chiropractor, physical therapist, all of the above, or only some of the above. Are some types of health professionals providers some of the time or all of the time or none of the time? Sometimes in Medicare a provider is a person and in other instances it is an entity.

As the agency attempts to expand on the legislative text of the PPACA and provide these definitions, inevitably there will be people who will disagree with how the agency has chosen to interpret a particular phrase or word. Historically, when such a dispute occurs, the outside aggrieved party could go to federal court and ask a judge to determine whether the agency was correct in their rulemaking in terms of adhering to Congressional intent. The courts, for their part, would often review the Committee Report, Conference Report or any other relevant documents to attempt to discern what exactly Congress meant by a particular phrase.

If the court’s review concluded that the agency adopted a policy that was inconsistent with the Committee Report or Conference Report, then the court could tell the agency to go back and rewrite the rule in a way that reflected Congressional intent. Conversely if there was documentation supporting the Agency’s interpretation OR if there is no Congressional information one way or the other, the Courts generally defer to the agency’s interpretation. In other words, in the absence of clear information indicating Congressional Intent, the Courts give the benefit of the doubt to the agency’s interpretation of Congressional Intent.

So where does that leave the American people (individuals and businesses) that will have to comply with the regulations adopted by the government?

Without any Committee or Conference Reports outlining Congressional intent, any effort to legally challenge the Agency’s interpretation or meaning of words or phrases will be severely hampered. In baseball, there’s a

phrase, “tie goes to the runner.” In cases where the baseball and a base-runner appear to the umpire to arrive at a base simultaneously, the runner is given the benefit of the doubt. When it comes to interpretations of the meaning of words and phrases included in the PPACA, “tie goes to the government.”

According to an analysis by the Congressional Research Service (CRS), hundreds of new regulations will have to be written over the next few years by the Department of Health and Human Services to give many of the legislative provisions meaning. Much of the rule writing responsibility will fall to the Centers for Medicare and Medicaid Services (CMS).

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### **Now that Insurance Companies are Being Reigned in, Who's Next?**

For more than a year, there has been a drumbeat of criticism laid at the feet of insurance companies – with much justification. While the high cost of private health insurance and some of their more egregious policies (i.e. rescission of policies when people got sick) drew plenty of attention during the healthcare reform debate, a new study on the cost of health care suggests that insurance companies are not solely to blame. The new report suggests that hospitals and physician groups with dominant market power are also responsible for some of the underlying drivers of higher healthcare costs and higher insurance premiums. A story, that went largely unreported during the healthcare reform debate.

A study just released by the Center for Studying Health System Change (HSC) examines the growing market power of many California hospitals and physicians to negotiate significantly higher payment rates from private insurers. The study's authors note, “Provider market power is the elephant in the room that no one wants to talk about in the national health care reform debate.”

HSC Senior Consulting Researcher Robert Berenson, MD of the Urban Institute, and coauthor of the study said “Health insurers have been squarely in the crosshairs and blamed for the high cost of private insurance, while the role of growing hospital and physician market power has escaped scrutiny.”

The authors suggest that the California experience may be a warning shot about the value of reform proposals that encourage hospitals and physicians to form tighter relationships through accountable care organizations. Although the study was released prior to the enactment of the Patient Protection and Affordable Care Act, it does not appear that it had any impact on the final legislation. The findings of this study may cause some in Congress to look into the issue of provider market domination and the impact this has on prices.

Study co-author Paul Ginsberg said, "Reform proposals that encourage hospitals and physicians to integrate, have the potential to improve quality and increase efficiency, but the savings may not be passed on to payers if provider market power to command higher prices goes unchecked."

The authors conclude their piece by pointing out that some policymakers who believe in the merits of increased integration of care delivery also believe that price regulation may be a prerequisite for payment reforms that encourage integration. In other words, in order for the ACO model to work, the government will need to heavily regulate prices to ensure that this payment method works.

According to a press release issued by the HSC, “The study identified three key factors in California that are driving the shift of negotiating power from private insurers to hospitals and physicians:

- Consumer demand for broader provider networks following the managed care backlash;
- Consolidation of hospitals into larger, powerful systems and tighter alignment with physicians; and
- Growing hospital and physician capacity constraints.”

Ironically, even health plans were quoted complaining about the market power of some of these larger, well-integrated groups with one saying, “We'd welcome some regulatory intervention to break up these monopolies because they are just killing us.”

The authors conclude their report with the following observation:

“While many providers have gained the upper hand with health plans, the study also found that certain factors have prompted some providers to limit the degree to which they exercise their market power. Some providers may balance their desire for high prices with the fragility of employer-sponsored insurance in their communities...”

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### **CMS announces a Reorganization**

On March 24, the Secretary of Health and Human Services announced a major reorganization of the Centers for Medicare & Medicaid Services (CMS). This restructuring is the first major

reorganization of the agency in nearly 10 years. The most significant change is that strategic planning and program integrity functions are being elevated and will be just as important as operations in the organizational hierarchy.

The reorganization creates four “Centers” to be run by Deputy Administrators. Previously there were three centers and each was run by a “Director”.

The Centers are:

- The Center for Medicare, which will serve as the focal point of Medicare program policies and operations, combining the operations of Medicare fee-for-service, Medicare managed care, and the Medicare prescription drug benefit. This Center will be led by Deputy Administrator Jonathan Blum.
- The Center for Medicaid, CHIP and Survey & Certification (formerly known as the Center for Medicaid and State Operations) will be led by Cindy Mann. Despite the name change, the functions of this Center will not change much, except Medicaid Integrity will be moved to the Center for Program Integrity.
- The Center for Program Integrity will consist of the Medicare Program Integrity Group of the Office of Financial Management and the Medicaid Program Integrity Group. The Center will be led by Peter Budetti a lawyer-physician who early in his career worked for Congressman Henry Waxman (D-CA) current Chairman of the Energy and Commerce Committee. Most recently, Budetti has been a professor at George Washington University.
- The Center for Strategic Planning will combine the Office of Research, Development and

Information, with the Office of Policy. This Center will be led by Anthony Rodgers, who is a former state Medicaid Director (Arizona) but most recently worked for a company called Health Management Associates, Inc (HMA). At HMA, Rodgers served as the principal consultant on health system strategic planning, health information technology, and health plan operations.

With the reorganization, the Center for Beneficiary Choices has been eliminated. The Center for Beneficiary Choices handled much of the policy and regulatory work surrounding both the Medicare Part C and Medicare Part D benefits. This work has not been consolidated into the Center for Medicare.

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### **March Madness Isn't Just for College Basketball Fans**

For many years the term “March Madness” has been used to describe the NCAA Men’s Division I Basketball Tournament. As Congress moved towards a final vote on Healthcare Reform, we saw a new meaning for that term!

Despite the pronouncements of numerous national pundits that healthcare reform was dead with the election of Scott Brown (R-MA) to the U.S. Senate, the President and Congressional Democrats forged ahead with a final vote on healthcare reform. By a vote of 219 – 212, the U.S. House of Representatives approved Healthcare Reform legislation previously passed by the U.S. Senate and sent the bill to the President. As noted above, on March 23<sup>rd</sup>, President Obama signed that bill, the Patient Protection and Affordable Care Act, into law (Public Law 111-148).

For many weeks after the nationally televised healthcare summit, the outcome of the final HCR vote was uncertain. But once it was clear that the votes were there for passage, the vote occurred.

Because of the unusual process the Democratic leadership used to get the votes to pass the PPACA, it was also necessary for Congress to adopt a Budget Reconciliation bill to “fix” problems with the bill they just passed.

For most people the process by which legislation gets enacted is immaterial. Most are interested only in the final outcome. But as was noted earlier, in this case, process may prove extremely important.

As the final vote approached, one Member of Congress was overheard saying to a colleague that he felt that with respect to healthcare reform, the House Democratic Leadership could see the light at the end of the tunnel. The Member to whom the comment was made turned and reportedly said, “Yeah, but the question is, is that the light of enlightenment and happiness, or the headlight of a train heading straight for us!”

Two detailed presentations on HCR and what it means for billing companies and their physician clients were delivered at the HBMA Spring Meeting in Baltimore, Maryland. If you were not able to attend the conference, contact the HBMA national office to see if you can obtain a copy of the slides. Also, over the next few months, a more detailed analysis of the various provisions of the bill will be provided to the membership by the HBMA Government Relations Committee.

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### **Berwick Nominated to be Next CMS Administrator**

The Centers for Medicare and Medicaid Services (CMS) has been without an official leader for more than two years. Beginning with the Bush Administration, there have been a series of “Acting” Administrators running the agency. The current “Acting” Administrator, Marilyn Tavenner, recently replaced the previous Acting Administrator Charlene Frizzera who was appointed early in the Obama Administration. Ms. Frizzera replaced the previous Acting Administrator Kerry Weems who served during the final year of the Bush Administration.

Recently, President Obama announced that he was nominating Donald Berwick, MD to be the next CMS Administrator. Although Berwick’s name had long been rumored as a finalist, his nomination took some by surprise. Berwick is well respected in the health policy community, but he has made some controversial comments in the past with regard to “rationing” of healthcare that will surely be the subject of questions during his confirmation hearing.

If confirmed, Berwick will bring a wealth of health policy experience to CMS. Currently, Berwick serves as a Professor in the Department of Health Policy and Management at Harvard University and he is President and CEO of the Institute for HealthCare Improvement (IHI). IHI is, according to the organization’s website, a “not-for-profit organization leading the improvement of health care throughout the world. Founded in 1991 and based in Boston, MA, IHI is a catalyst for change, cultivating innovative concepts for improving patient care and implementing programs for putting those ideas into action.” Berwick and the Institute have been strong advocates for linking provider payments to quality.

Senate Finance Committee Chairman Max Baucus (D-MT) had this to say in response to Berwick's nomination:

"Dr. Berwick is an experienced health policy expert and researcher whose career has focused on innovative and effective ways to improve health care quality. Implementing innovative ideas that work and boosting health care quality will be critical goals for the next Administrator of CMS, particularly in our fight to deliver better health care outcomes and lower costs for patients across the country. Improving health care quality was a major part of the landmark health reform bill passed this year and the CMS Administrator will play a crucial role implementing that law. I look forward to an expeditious review of Dr. Berwick's nomination in the Finance Committee."

Baucus Chairs the Senate Finance Committee, the Committee that must first consider and approve Berwick's nomination before it can go to the full Senate for confirmation.

Baucus' positive opinion of Berwick is not shared, however, by all Senators.

Sen. John Barrasso (R-WY) an Orthopedic Surgeon before being elected to the U.S. Senate had this to say about Dr. Berwick, "... (Berwick) has a history of support for government rationing of health care resources, not on the grounds of quality, not on the grounds of survivability, but on the grounds of cost."

In addition, Pat Roberts (R-KS) a member of the Senate Finance Committee said he will be hard-pressed to support Berwick's confirmation because of his (Berwick's) alleged views on rationing.

Although there has been nothing said about Berwick's nomination that suggests he won't be confirmed by the Senate (he only needs a simple majority) his nomination hearings are sure to be interesting theater. Confirmation hearings should begin prior to the Senate's Memorial Day recess; however, that is subject to change in the event Committee investigators find information in Dr. Berwick's background that requires further investigation.

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### **New Report Challenges CBO's Conclusions on the Fiscal Impact of the PPACA**

Richard Foster is a name that is unfamiliar to most Americans but in the green eyeshade world of actuarial science, he is a rock star. Foster is the long-time Chief Actuary of the Centers for Medicare and Medicaid Services (CMS). As such, he is responsible for conducting independent financial analysis and long-range assessments of the financial stability of both the Medicare and Medicaid programs as well as produce annual reports on National Health Expenditures, looking at past, present and projected public and private spending on healthcare.

During the debate on Healthcare Reform, considerable rhetoric was devoted to the phrase, "bending the long-term cost curve". President Obama, on more than one occasion, assured the American people that his healthcare reform plan would save money and if it didn't, he would take out his veto pen and reject the legislation.

In fact, when the final numbers were in, the Congressional Budget Office (CBO) announced that enactment of the Patient Protection and Affordable Care Act would reduce the federal deficit by more than \$100 Billion over the 10 year period covered by their estimates (2010 – 2020). Further, CBO analysts pronounced that in future years, those beyond their 10 year estimate, they were confident that there would be long-term reductions in overall health expenditures compared to what would have been spent absent healthcare reform. This news was widely embraced by both the President and the Democratic Leadership that wrote the PPACA. Republicans, for their part, cast a skeptical eye and suggested that perhaps the numbers presented by CBO did not tell the entire story.

Less than one-month after the PPACA was signed into law, Foster has issued a new, 38 page analysis of the PPACA that concurs with many of CBO's projections. But on two key points, the Chief Actuary

contradicts CBO's conclusions. First, with regard to overall spending on healthcare (government and private sector) over the next 10 years, Foster concludes that healthcare spending will actually be higher than previously projected (thereby violating the Presidents "bend the cost curve" promise). Second, the Chief Actuary points out that the Congressional Budget Office effectively "double booked" the cuts in Medicare spending thus allowing CBO to falsely proclaim that the PPACA reduced the federal deficit by more than \$100 Billion over 10 years.

With regard to the true cost of the PPACA, Foster's report concludes that for the years 2010 through 2019, total healthcare expenditures (government and private sector) will be significantly higher than what would have occurred if the PPACA had not been enacted. The Chief Actuary further concludes that as a result of these higher expenditures, the American people could experience price increases, greater cost-shifting and, the Chief Actuary predicts, many providers could refuse to see patients enrolled in programs that have traditionally paid below average reimbursements.

As to the charge of double booking the PPACA adopted Medicare "savings", the Chief Actuary noted that as a result of the cuts in Medicare spending, the Medicare Trust fund, instead of being exhausted in 2017 as had been previously projected, the Trust Fund would now have sufficient funds to operate through 2029. This stabilization is a good thing and the Congress and the President should be commended for taking this action.

Unfortunately, Foster goes on to point out that Congress, after taking credit for extending the life of the Medicare Trust Fund, then applied these savings against the new federal general revenue spending mandated by the PPACA and effectively masked the huge federal deficits the legislation was creating. Specifically, the actuary said,

"In practice, the improved HI financing cannot be simultaneously used to finance other Federal Outlays (such as the coverage expansions) and to extend the Trust Fund, despite the appearance of this result from the respective accounting conventions."

In other words, the accounting rules CBO and Congress use that permit reductions in Medicare spending to be used to extend the life of the Medicare Trust Fund and simultaneously reduce the size of the general fund deficit may be permissible in Congress, but in the real world of accounting, this is known as double booking.

Although Foster's report has been released and is circulating around Congress, it has yet to be officially released by the White House for posting on the CMS website.

Lest anyone think that Foster and his staff are politically motivated, during the Bush Administration and the years when Republicans controlled Congress, Foster and his staff came under intense political fire because his analysis of Bush Administration Medicare Reforms often were at odds with both CBO and the President's advisors. During these years, Congressional Democrats often praised Foster as an actuarial Paul Revere running around warning, the deficits are coming, the deficits are coming.

If you would like to read Foster's report, you can visit:

[http://republicans.waysandmeans.house.gov/UploadedFiles/OACT\\_Memorandum\\_on\\_Financial\\_Impact\\_of\\_PPACA\\_as\\_Enacted.pdf](http://republicans.waysandmeans.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_PPACA_as_Enacted.pdf)

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### **You Say Outsourcing and I say Insourcing – Can't We all Just Get Along...**

Off-shoring or out-sourcing continues to be a hotly debated topic within the medical billing community. Some see it as an abandonment of America and American jobs whereas others view it as a rational business reaction necessary to lower costs in a competitive business environment.

Regardless of where one falls on the topic, the debate will not be ending any time soon and as a result of healthcare reform, could be reignited as more and more companies from a variety of sectors consider

“outsourcing” some work to an overseas partner as a means of circumventing some of the employer mandates included in the healthcare reform legislation.

The Congressional Research Service (CRS) recently issued a report that attempts to shed some light on this controversial topic. With a rather pedestrian title, “Outsourcing and Insourcing Jobs in the U.S. Economy: An Overview of Evidence Based on Foreign Investment Data” the authors try to take a scholarly look at a topic that generates passions typically seen in the ring of the World Wrestling Federation.

Although the authors go to great pains to demonstrate that economic activity relative to job creation goes in both directions (in-sourcing as well as out-sourcing), the inescapable conclusion is that in difficult economic times, there is far greater pressure to move U.S. jobs overseas than there is pressure for foreign investors to create jobs in the U.S. The CRS report notes:

“The data also show that U.S. direct investment abroad and foreign direct investment in the United States generally move in the same direction so that those forces which encourage U.S. firms to invest abroad also encourage foreign firms to invest in the United States.”

It then goes on to state,

“On the other hand, an economic slowdown among U.S. parent companies relative to the rate of growth among foreign affiliates likely would lead to an overall decline in employment throughout the economy.”

“The uneven effect of an economic slowdown among U.S. parent companies on their investment behavior abroad likely means that jobs outsourcing may appear to be more acute during periods in which the long-term structural changes in the economy coincide with the short-term economic adjustments that arise from a slowdown in the rate of growth of the U.S. economy.”

As I read the report, I was reminded why I really disliked Econ in College, but after I recovered from those nightmares, I was reminded of a comment a former colleague of mine made (he was an economist) when he said some day he wanted to meet a “one-handed” economist because he was sick of hearing his colleagues saying in response to direct questions, “well on the one hand, you could have this result, but on the other hand, you could have that result.”

Based upon a close reading of the CRS report, it appears that there are no one-handed economists working at the Congressional Research Service.

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### **Fraud and Abuse Gaining More Attention**

On Thursday, March 4<sup>th</sup> the House Labor HHS, Education Appropriations Subcommittee conducted a hearing on “Combating Health Care Fraud and Abuse” The following people testified at the hearing:

Bill Corr, Deputy Secretary of HHS

Gary Grindler, Acting Deputy Attorney General

Dan Livenson, HHS Inspector General

Omar Perez, a special agent from the HHS IG’s office and a leader of the Miami Health Care Fraud Task Force

Not surprisingly, all of the Members in attendance – Democrats and Republicans – came out strongly against waste, fraud and abuse in the Medicare program.

Mr. Corr said the Department's sole focus is minimizing waste, fraud and abuse. To support this claim, he pointed to the President's budget and also highlighted the formation of the HEAT task force. Based upon a newly completed review of Medicare claims data, the Department wants to focus its attention on three areas:

1. Expand sites visits and inspections in high risk areas including Florida and Texas with discretionary funds.
2. The HHS Secretary and Attorney General will convene a summit on health care fraud at the start of this program.
3. Strengthen their ability to prevent improper payments.

According to the DOJ witness, Mr. Grindler, nearly \$15 billion has been returned to the federal treasury due to their efforts and \$13.1 billion of the \$15 billion was added to the Medicare trust fund in FY 2008. Currently, for every dollar they invest in health care fraud, they have a four dollar return.

Mr. Levinson stated that in 2009 the OIG received increased funding for the first time in many years and as a result of that increased funding, was able to return \$11 million in recovered funds to the Treasury. Levinson noted that Miami continues to be a hot spot for Medicare fraud, and they have found other states where people are treated unnecessarily in order to receive the maximum payment.

During the question period of the hearing, Representative Denny Rehberg (R-MT) asked about the Recovery Audit Contractor (RAC) program. Thus far, the RAC program has resulted in generating more than \$60 million in "savings" in the seven states that have been the primary focus of RAC audits. In attempting to determine where to take this program next, CMS will focus on cities where billing patterns are most pronounced. Rehberg asked for a classified hearing to review the criteria and cities selected since the Agency is asking for money. No commitment was made.

In response to a question from Representative Nita Lowey (D-NY) about the efforts to reduce the Error Rate, the witnesses noted that the current error rate is 7.8% and ½ of this rate is attributed to improper documentation, such as physicians did not sign the paperwork properly. The other half is attributed to payments that could be fraud or are improperly used money in all Medicare parts. To bring the latter rate down, government enforcement has deterred and prevented fraud and improper payments with strike force teams. The existing strike forces will continue receiving support and use their previous success to train and prepare future teams.

It is likely that the Congress will approve the additional funds requested for more aggressive investigations into Medicare fraud and abuse.

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### **HHS Creates new "Office of Consumer Information and Insurance Oversight"**

The recently enacted Patient Protection and Affordable Care Act affords vast new powers and responsibilities to the Secretary of Health and Human Services when it comes to oversight and regulations of commercial insurance. To assist the Secretary with carrying out these new powers, Health and Human Services (HHS) Secretary Kathleen Sebelius has announced the creation of a new Office of Consumer Information and Insurance Oversight.

In general, this office is charged with providing, "leadership for implementing the provisions of the health reform bill that address private health insurance." The Office will report directly to the Secretary of HHS.

Included in the *Federal Register* notice announcing the new office, it states that the office will be responsible for:

- (1) Implementing, monitoring compliance with, and enforcing both the new rules

governing the insurance market and the new rules regarding medical loss ratios;

(2) Performing rate reviews; and

(3) Issuing rate review grants to states.

In addition staff in this new office will be responsible for administering both the temporary high-risk pool programs as well as associated funding to states and the early retiree reinsurance program.

The Consumer Affairs staff in the Insurance Oversight Office will be responsible for:

(1) Collecting, compiling, and maintaining comparative pricing data for the Department's Web site;

(2) Providing assistance to enable consumers to obtain maximum benefit from the new health insurance system; and

(3) Establishing and issuing consumer assistance grants to states.

Finally, this new office will be responsible for assisting with the establishment of the new state-based Health Benefit Exchanges mandated under the Patient Protection and Affordable Care Act. The staff will be:

(1) Developing and implementing policies and rules governing state-based exchanges;

(2) Establishing and issuing planning grants to states; and

(3) Overseeing the operations of exchanges.

No word on when the new Office will begin hiring, but it is expected that there will be numerous job openings within the next few months. Although the Federal government is an equal opportunity employer and does not discriminate based upon race, religion, national origin, sexual preference or ethnicity, former insurance company executives are not urged to apply.

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### **Doctors Working Fewer Hours**

According to a recently released study, an increasing number of U.S. physicians are working fewer and fewer hours and also seeing fewer patients. This reduction in physician productivity is adding to the physician shortages already being experienced in some areas of the country.

Between 1996 and 2008, the average number of hours worked per week by physicians dropped from 55 hours to 51 hours. The study was published in the current issue of the Journal of the American Medical Association (JAMA). By comparison, registered nurses saw little to no drop in hours worked.

Significant increases in patient waiting time have been reported in many major cities with the most dramatic increase seen in Boston. The authors of the study did not offer an opinion as to whether the enactment of universal health insurance a few years ago by the state of Massachusetts – and the resultant increase in demand for healthcare – in any way contributed to the longer waiting times for patients in Boston.

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### **Meaningful Use Comments**

As has been previously reported, the Centers for Medicare and Medicaid Services (CMS) issued proposed criteria physicians would be required to meet as a condition for receiving the Electronic Health Record (EHR) incentive payments from Medicare or Medicaid. A preliminary review of the comments submitted in advance of the March 15<sup>th</sup> deadline suggests that broad swaths of the healthcare community are not happy with the standards. A common theme amongst early comments appears to be that there are too many standards and it is unlikely that most physicians could meet all 25 proposed standards in order to qualify for the EHR incentive payments.

Several commenters expressed the concern that because of the high standards for qualifying for the incentive payments and the conclusion by many physicians that they cannot qualify, many physicians would simply opt to forego investing in EHR and accept the 1% penalty that would occur if a provider fails to adopt EHR. Some physicians and small group providers maintain that due to their age and the relatively low penalty compared to the cost of investing in an EHR, they would be better off paying the penalty if they couldn't qualify for the incentive payment.

It is conceivable that CMS will change the "meaningful use" rule to reflect the concerns of the comments when it publishes the final rule. According to CMS, they plan to issue the final rule in "late spring" in order to allow providers sufficient time to qualify for the incentive payments as quickly as possible. CMS staff pointed out that "Spring" runs until late June.

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### **PPAC Meeting Update and Low Light**

On March 8, 2010, the Practicing Physicians Advisory Council (PPAC) held its quarterly meeting at the Centers for Medicare and Medicaid Services (CMS) headquarters in Baltimore, MD. Unbeknownst at the time, this would be the last meeting of the Council. A few weeks before this meeting, language was secretly inserted into the Patient Protection and Affordable Care Act that resulted in the abolishment of this Council.

Supporters of the Council pointed out that in the grand scheme of things, losing PPAC may not be the most troubling thing to come out of the Patient Protection and Affordable Care Act but it seems ironic that concurrent with adopting the most sweeping changes in our nation's healthcare delivery system, the Congress would eliminate the one Council created to advise the government on how government policies were affecting practicing physicians.

The language repealing this Council is hidden in a section of the bill dealing with a directive to CMS that the agency update "misvalued" codes.

Here's how the language appears in Section 3134(b)(2) of the PPACA:

(2) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES- Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)) is repealed.

That's it. With those few words, a Council that has provided valuable information and feedback to CMS (see following report) will no longer exist.

The March 8<sup>th</sup> meeting opened with Bill Rogers, MD, Director, Physicians Regulatory Issues Team (PRIT), giving a report to the Council which centered on two main issues. First, the ban on not covering services ordered by a physician who is not enrolled in Medicare (This policy has been delayed until January 3, 2011) and second, CMS is reviewing the activities of one of the Medicare payment contractors who were rejecting claims of certain doctors in Iowa due to the illegibility of their signatures.

Dr. Rogers opined that CMS will not force doctors to change their signatures but rather will require them to certify their signatures periodically. (This situation was covered in a subsequent presentation).

On a related note, Dr. Rogers has been a speaker at HBMA meetings and HBMA has been assured that although PPAC has been eliminated, Dr. Rogers' position as well as the PRIT will continue.

Next, the Director of the Division of Provider and Supplier Enrollment, Jim Bossenmeyer, gave a presentation to the Council of the Provider Enrollment, Chain and Ownership System (PECOS).

Mr. Bossenmeyer made the following points:

1. If a physician is going to reassign benefits to a medical group, that group must have an approved enrollment in PECOS.
2. If a physician has not enrolled or updated their Medicare enrollment since November, 2003, they should enroll as soon as possible.
3. He strongly urged physicians to take the necessary steps to secure their PECOS information (i.e. user name and password) so that it does not fall into the hands of people who would use the information to commit fraud.

Members of the Council had a number of comments to make about the PECOS program. The major ones included:

1. CMS needs to do an extensive outreach to physicians about the program.
2. There needs to be a live person to answer inquiries on the toll free number and not just a message machine.
3. CMS needs to compensate physicians for the cash flow shortages that arise due to enrollment that are not the fault of the physician.

Next, Tony Trenkle, Director, the CMS Office of E-Health Standards and Services gave the Council an update on the Electronic Health Records (EHR) initiative.

In a pointed discussion, the Council members made a variety of observations on this program to Mr. Trenkle.

1. Some practices already have an EHR system which was created through great time, effort, and financial resources and there is a great fear that these systems will be obsolete under the new Meaningful Use rules.
2. The formulas using a numerator and a denominator calculation for certain MU criteria are too complicated and time consuming.
3. Specialty groups have to be included in any development of evidence based medical treatment that would become a part of an electronic system.
4. In the list that physicians are supposed to pick their specialty, not all specialties are listed.
5. Some health systems are marketing their electronic systems to their hospitals and affiliated physician groups. Will these systems allow access by a physician who is not part of the system? It should be.
6. Hospital based physicians should have greater access to this program on an individual basis and not through their hospital.
7. The definition of "Hospital" should be expanded to include ambulatory surgical care centers, emergency care facilities, and other clinical settings not in the hospital.

Finally, the director of the agency's Program Integrity Group, Kimberly Brandt, reported that CMS has embarked on a program to find the practitioners, suppliers, and beneficiaries who receive the highest compensation from Medicare to see if they are actually entitled to these claims. On this point, she reported that in the last quarter of 2009, an analytical focus on those considered "high risk" resulted in the revocation of billing privileges of 265 durable medical equipment (DME) suppliers, and the placement on "pre-payment review" of 539 additional suppliers and 37 physicians. Additionally, 2,191 high-utilizing beneficiaries were also placed on pre-payment review for enhanced scrutiny. CMS will attempt to verify clinical relationships through claims history data between high ordering physicians and beneficiaries for whom they ordered equipment. This review found the highest billers were in New York, North Carolina, Florida, Michigan, Texas, Illinois, and California.

She also reported that beginning in October 1, 2009, CMS implemented two new edits to ensure that the ordering/referring provider for a Part B claim:

1. Has a current enrollment record in Medicare meaning that the provider has enrolled or updated his/her enrollment record within the past 5 years and the NPI is in the record; and
2. Is of a specialty that is eligible to order and refer.

Until January, 2011 the provider who does not pass these two edits will receive a warning message with their remittance after that their claims will be rejected.

The Council made a number of comments to Ms. Brandt but there were two in particular that were made with great emphasis and emotion.

1. CMS needs to publicize widely that the fraud rate for physicians is less than 1% of the total fraud in the Medicare system. The public needs to know that the physician that they have entrusted their care to is not defrauding Medicare.
2. The threat of audits of Medicare claims is having a **strong chilling effect** on the willingness of physicians to serve Medicare patients and this could cause an **acute shortage** of Medicare providers across the country.

Finally, the Council members communicated to these CMS officials that there is a great deal of hostility in the physician community over the RAC program. In particular, Council members felt that the 15 day response period to rebut the RAC's finding of over payment was much too short, particularly in light of the delays in the delivery of mail in many parts of the country.

Again, with the demise of entities such as the Council, federal bureaucrats may be further isolated from the provider community and without benefit of their insight and observations from the "real world" one can only imagine the types of policies that may percolate from CMS.

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### **Will a Freeze of non-Defense Discretionary Spending Balance the Budget?**

President Obama recently proposed that in order to try to bring the federal budget into balance over the next ten years, he would recommend that Congress freeze non-defense discretionary spending for the next three years. Recently, the non-partisan Congressional Research Services (CRS) examined that idea.

According to the CRS, in fiscal year (FY) 2009, the federal budget deficit, relative to the size of the economy, reached a level not seen since the end of World War II. Deficit levels are projected to remain elevated through FY 2011. The budget deficit for FY 2011, according to CBO's analysis of the President's budget, is projected to be \$1,342 billion (or \$1.34 Trillion). This figure represents approximately 4.0% of our nation's Gross Domestic Product (GDP).

The President proposes to freeze non-defense discretionary spending for the next three fiscal years (FY 2011-FY 2013) at the FY 2010 level (i.e., spending levels would not be adjusted for inflation). After FY 2013, growth in non-defense discretionary spending would be linked to inflation. For purposes of this proposal, "Non-defense discretionary spending" is defined as discretionary spending outside of defense, homeland security, veteran's affairs, and international affairs. If enacted in this form, the President's budget projects that this would save approximately \$250 billion over the next 10 years.

The Obama Administration projects that without any change in policy, the federal deficit will grow to 5.6% of GDP in FY 2020. However, if President's proposed "freeze" were to be implemented, the President projects that the deficit would "fall" to 4.2% of GDP in FY 2020. Please note that the term "fall" is relative to projected spending. Even with the freeze, the size of the federal deficit would still grow compared to its current levels. The current deficit is 4% of GDP and with a freeze in non-defense domestic spending, the deficit would grow to 4.2%.

According to the CRS, in order to achieve even greater deficit reduction, larger cuts in spending would be needed.

Based upon CRS's analysis, even if non-defense discretionary spending were completely eliminated (i.e. cut to zero), the deficit would only fall from 4.0% of GDP in FY2011 to 3.3% of GDP in FY2020. In order to balance the budget, significant additional spending cuts, tax increases, or a combination would still be required. These would have to come from defense/national security programs (those excluded from the President's freeze) or cuts/changes in entitlement programs such as Medicare, Medicaid and Social Security.

CRS concluded by noting, "The proposal to place a three-year freeze on non-security discretionary spending, represents a small reduction in the federal budget deficit. Freezing this spending does not address longer-term budgetary challenges."

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### CMS Transmittals

The following Transmittals were published by CMS between March 1, 2010 and May 1, 2010.

Transmittal Number	Subject	Effective Date
<a href="#">R1962CP</a>	Discarded Drugs and Biologicals Updates	07/30/2010
<a href="#">R1961CP</a>	Payment for Replacement of Oxygen Equipment In Bankruptcy Situations	10/04/2010
<a href="#">R695OTN</a>	Addition of Repair Codes to the List of Healthcare Common Procedure Coding System (HCPCS) Codes Payable Under the Instructions Provided in Change Requests (CRs) 6573 and 5917	10/04/2010
<a href="#">R691OTN</a>	The Transition of a Segment of the Wisconsin Physicians Service (WPS) Legacy Workload (Formerly Processed by Mutual of Omaha) for the States of Colorado, New Mexico, Oklahoma, and Texas to the J4 A/B Medicare Administrative Contractor (MAC)	10/18/2010
<a href="#">R689OTN</a>	Analysis and Design to Ensure That Coordination of Benefits Agreement (COBA) Trading Partners Can Accept and Process Acute Care Episodic (ACE) Demonstration Claims For Crossover Purposes	10/04/2010
<a href="#">R690OTN</a>	Durable Medical Equipment National Competitive Bidding Implementation -- Phase 10C: Exception for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan	10/04/2010
<a href="#">R168FM</a>	Recovery Audit Contractors (RACs)	06/01/2010
<a href="#">R123BP</a>	Determining Self-Administration of Drug or Biological	07/30/2010
<a href="#">R1963CP</a>	Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2010	07/06/2010
<a href="#">R169FM</a>	Recovery Audit Contractors (RACs)	06/01/2010
<a href="#">R693OTN</a>	Instructions Regarding the Processing of Inpatient Claims for Gender/Procedure Conflict	10/04/2010
<a href="#">R688OTN</a>	Durable Medical Equipment National Competitive Bidding Implementation; Phase 10G: Paying for Oxygen Equipment when Grandfathered	04/29/2010
<a href="#">R687OTN</a>	Additional Medicare Secondary Payer (MSP) Claims Processing Instructions for the Common Working File, Medicare Part B, and Durable Medical Equipment (DME)	10/04/2010

Shared Systems Regarding Medicare Secondary Payer Claims that Contain a Claim Adjustment Reason Code (CARC) 19, 20 or 21

<a href="#">R686OTN</a>	Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prosthesis Healthcare Common Procedure Coding System (HCPCS) Code	10/04/2010
<a href="#">R1958CP</a>	Skilled Nursing Facility (SNF) Health Insurance Prospective Payment System (HIPPS) Coding Updates Effective October 1, 2010	10/04/2010
<a href="#">R1957CP</a>	Update to the HCPCS Codes for Payment of Surgical Dressings in Indian Health Service (IHS) Providers	10/04/2010
<a href="#">R1956CP</a>	Remittance Advice Coding to Identify Claims Subject to the Limitation on Home Health Prospective Payment System (HH PPS) Outlier Payments	10/04/2010
<a href="#">R677OTN</a>	Expansion of the Current Scope of Editing for Attending Physician Providers for Free-Standing and Provider-Based Home Health Agency(HHA) Claims Processed by Medicare Regional Home Health Intermediaries (RHHIs)	10/04/2010
<a href="#">R1953CP</a>	Use of 12X Type of Bill (TOB) for Billing Colorectal Screening Services	10/04/2010
<a href="#">R682OTN</a>	Sending DMEPOS Medicare Summary Notices on a Monthly Schedule to all beneficiaries in Miami-Dade, Broward and Palm Beach County Zip Codes in Florida	10/04/2010
<a href="#">R683OTN</a>	Analysis of the Expansion of the Legal Business Name (LBN), Practice Location and Special Payment Address Fields in the Viable Medicare System (VMS)	10/04/2010
<a href="#">R685OTN</a>	Provide Mapping of Shared Systems Data to the HIPAA835 and 837 Formats	10/04/2010
<a href="#">R74MSP</a>	New Medicare Secondary Payer Insurer Type Codes	10/04/2010
<a href="#">R684OTN</a>	New Medicare Summary Notice (MSN) Message for Higher than Expected (PPS) Payments	10/04/2010
<a href="#">R679OTN</a>	Carrier and Part A and Part B Medicare Administrative Contractors (A/B MACs) Implementation of Title 42 Code of Federal Regulations (CFR) Section 424.535	10/04/2010
<a href="#">R1952CP</a>	Enhancements to Home Health (HH) Consolidated Billing	10/04/2010
<a href="#">R680OTN</a>	Deactivation Letters for the Fiscal Intermediary Standard System (FISS)	10/04/2010
<a href="#">R681OTN</a>	Requirement for Submission of Shared Systems Data to the Integrated Data Repository (IDR)	10/04/2010
<a href="#">R1951CP</a>	Removal of the Provider Reporting Requirement for Total Number of Therapy Visits using Value Codes 50-53	10/04/2010
<a href="#">R676OTN</a>	Payment of Oxygen Contents to Suppliers After the 36th Month Rental Cap under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program	10/04/2010
<a href="#">R674OTN</a>	Temporary 3 Percent Rural Add-On for the Home Health Prospective Payment System (HH PPS)	05/24/2010
<a href="#">R65DEMO</a>	Clarification of Unsolicited Response and Auto Adjustment of	07/06/2010

	Claims under CR 6001 for the Medicare Acute Care Episode (ACE) Demonstration.	
<a href="#">R334PI</a>	Update to Site Verification Process	05/24/2010
<a href="#">R675OTN</a>	Customer Information Control System (CICS) Production Region Merge of the Part A Arkansas, Louisiana and Mississippi Workloads in Preparation for the J7 A/B Medicare Administrative Contractor (MAC) Implementation.	08/02/2010
<a href="#">R167FM</a>	Recovery Audit Contractors (RACs)	05/24/2010
<a href="#">R1950CP</a>	Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update	07/06/2010
<a href="#">R166FM</a>	Notice of New Interest Rate for Medicare Overpayments and Underpayments 3rd Notification for FY 2010	04/23/2010
<a href="#">R671OTN</a>	Implementation of a File-Based Recovery Audit Contractor (RAC) Mass Adjustment Process in VMS (This CR Rescinds and Fully Replaces CR 6549)	07/06/2010
<a href="#">R673OTN</a>	Modification of the File-Based RAC Mass Adjustment Process in FISS (This CR Rescinds and Fully Replaces CR 6555)	07/06/2010
<a href="#">R1946CP</a>	Billing and Processing Claims with Unlimited Occurrence Span Codes (OSCs)	N/A
<a href="#">R670OTN</a>	Allow Zoned Program Integrity Contractors (ZPICs) to Access Medicare Administrative Contractors (MACs) by ZPIC Zone	N/A
<a href="#">R1945CP</a>	New Legislation to Allow Independent Laboratory Billing for the Technical Component of Physician Pathology Services for Hospital Inpatients and Outpatients	07/09/2010
<a href="#">R1944CP</a>	Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority and Examples of Application of Government Entity Exclusion. This CR rescinds and fully replaces CR 6544.	07/09/2010
<a href="#">R122BP</a>	Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority and Examples of Application of Government Entity Exclusion. This CR rescinds and fully replaces CR 6544.	07/09/2010
<a href="#">R669OTN</a>	Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	N/A
<a href="#">R58SOMA</a>	Revision of Exhibit 63, List of Documents in Certification Packet (Initial Certifications Include Initial Denials)	04/09/2010
<a href="#">R1943CP</a>	April 2010 Update to the Ambulatory Surgical Center (ASC) Payment System	04/05/2010
<a href="#">R1940CP</a>	Extension of Reasonable Cost Payment for Clinical Lab Tests Furnished by Hospitals with Fewer Than 50 Beds in Qualified Rural Areas	07/06/2010
<a href="#">R1942CP</a>	Update to the Medical Conditions List and Instructions	05/03/2010
<a href="#">R668OTN</a>	HIPAA 5010/D.0 Project Receipt, Control and Balancing Second Phase	07/06/2010
<a href="#">R667OTN</a>	Health Insurance Portability and Accountability Act (HIPAA) 005010 837 Institutional (837I) Edits and 005010 837	07/06/2010

Professional (837P) Edits - July Version

<a href="#">R663OTN</a>	Update to List of ICD-9-CM Diagnosis Codes Not Requiring the Q0 Healthcare Common Procedure Coding System (HCPCS) Modifier for Automatic Implantable Cardiac Defibrillator (ICD) Services Provided in a Clinical Study	07/06/2010
<a href="#">R119NCD</a>	Positron Emission Tomography (NaF-18) to Identify Bone Metastasis of Cancer	07/06/2010
<a href="#">R1936CP</a>	Claim Status Category and Claim Status Code Update	07/06/2010
<a href="#">R332PI</a>	Reporting Changes in Surety Bonds	06/28/2010
<a href="#">R662OTN</a>	Conference Call and Research Hours in Support of CR 5949	07/06/2010
<a href="#">R666OTN</a>	Update ViPS Medicare System (VMS) to Deactivate Billing Numbers for Non-Frequent Billing Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers.	10/04/2010
<a href="#">R1937CP</a>	Positron Emission Tomography (NaF-18) to Identify Bone Metastasis of Cancer	07/06/2010
<a href="#">R664OTN</a>	Implementation of the HIPAA Version 5010 276/277 Claim Status Multi-Carrier System (MCS) Only Transaction Pairing Fix	07/06/2010
<a href="#">R1938CP</a>	April 2010 Update to the Ambulatory Surgical Center (ASC) Payment System	04/05/2010
<a href="#">R661OTN</a>	Validating the Billing of End Stage Renal Disease (ESRD) 50/50 Rule Modifier	04/05/2010
<a href="#">R1935CP</a>	Screening for the Human Immunodeficiency Virus (HIV) Infection	07/06/2010
<a href="#">R118NCD</a>	Screening for the Human Immunodeficiency Virus (HIV) Infection	07/06/2010
<a href="#">R660OTN</a>	Version D.0 Inbound National Council for Prescription Drug Programs (NCPDP) Flat File Implementation	N/A
<a href="#">R659OTN</a>	Reporting of Recoupment for Overpayment on the Remittance Advice (RA)	N/A
<a href="#">R1934CP</a>	Billing and Processing Claims with Unlimited Occurrence Span Codes (OSCs)	N/A
<a href="#">R653OTN</a>	Clinical Laboratory Fee Schedule (CLFS) - Special Instructions for Specific Test Codes (CPT Code 80100, CPT Code 80101, CPT Code 80101QW, G0430, G0430QW, and G0431QW)	04/05/2010
<a href="#">R329PI</a>	Change in Provider Enrollment Timeliness Standards for Certain Paper Applications	06/21/2010
<a href="#">R328PI</a>	Ordering/Referring Providers Who Are not Enrolled in Medicare	04/19/2010
<a href="#">R1933CP</a>	Clinical Laboratory Fee Schedule (CLFS) - Medicare Travel Allowance Fees for Collection of Specimens	04/05/2010
<a href="#">R656OTN</a>	Health Insurance Portability and Accountability Act (HIPAA) 005010 837 Institutional (837I) Edits and 005010 837 Professional (837P) Edits - July Version	07/06/2010
<a href="#">R657OTN</a>	Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Version 5010 Catch-up Phase Two - MAC Jurisdiction 9 Only	05/03/2010

<a href="#">R658OTN</a>	Jurisdiction 10 A/B MAC Merge of the Part B Alabama, Georgia, and Tennessee CICS Production and User Acceptance Test Regions	07/31/2010
<a href="#">R655OTN</a>	HIPAA 5010 Activity-Testing of 5010 CRs	N/A
<a href="#">R654OTN</a>	Beta Testing of the HIPAA Version 5010 Common Edits and Enhancements Module (CEM) at Part A/B MAC Local Data Centers	04/30/2010
<a href="#">R652OTN</a>	Medically Unlikely Edits (MUE)	04/05/2010
<a href="#">R1932CP</a>	Dialysis Adequacy, Infection and Vascular Access Reporting	07/06/2010
<a href="#">R327PI</a>	Signature Guidelines for Medical Review Purposes	04/16/2010
<a href="#">R651OTN</a>	5010-D.0 Project Receipt, Control and Balancing Initial Phase for Durable Medical Equipment (DME) Only	N/A
<a href="#">R649OTN</a>	Health Insurance Portability and Accountability Act (HIPAA) 5010 Error Corrections	N/A
<a href="#">R1931CP</a>	Revision of the Internet Only Manual (IOM) to Remove References to Purchased Diagnostic Test and Replace With Language Consistent With the Anti-Markup Rule	06/14/2010
<a href="#">R326PI</a>	Revision of the Internet Only Manual (IOM) to Remove References to Purchased Diagnostic Test and Replace With Language Consistent With the Anti-Markup Rule	06/14/2010
<a href="#">R27COM</a>	Change in Provider Customer Service Program Requirements	04/12/2010
<a href="#">R649OTN</a>	Health Insurance Portability and Accountability Act (HIPAA) 5010 Error Corrections	N/A
<a href="#">R650OTN</a>	DME MAC and NSC MAC Processing Do Not Forward Code Notification and Action	07/06/2010
<a href="#">R15P232</a>	Updates Chapter 32, Home Health Agency Cost Report	N/A
<a href="#">R9P229</a>	This transmittal updates Chapter 29, Independent Rural Health Clinic (RHC)/Freestanding Federally Qualified Health Center (FQHC) Cost Report, (Form CMS-222-92).	N/A
<a href="#">R117NCD</a>	Outpatient Intravenous Insulin Treatment (Therapy)	04/05/2010
<a href="#">R1930CP</a>	Outpatient Intravenous Insulin Treatment (Therapy)	04/05/2010
<a href="#">R1929CP</a>	Point of Origin for Admission or Visit Codes Update to the UB-04 (CMS-1450) Manual Code List	07/06/2010
<a href="#">R648OTN</a>	Additional ICD-9 Codes Analysis and Processing direction (Institutional Claims Only)	N/A
<a href="#">R115NCD</a>	Percutaneous Transluminal Angioplasty (PTA) of the Carotid Artery Concurrent with Stenting	04/05/2010
<a href="#">R1927CP</a>	April 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.1	04/05/2010
<a href="#">R116NCD</a>	Repeal of Section 20.10, Cardiac Rehabilitation (CR) Programs	04/05/2010
<a href="#">R1928CP</a>	Correction to Processing of Non-Covered Revenue Codes	07/06/2010
<a href="#">R647OTN</a>	Implementation of Common Edits and Enhancements (CEM) Software at Part A/B MAC Local Data Centers	07/06/2010
<a href="#">R62GI</a>	July 2010 Update to the CMS Standard File for Reason Codes	07/06/2010

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<a href="#">R1925CP</a>	Percutaneous Transluminal Angioplasty (PTA) of the Carotid Artery Concurrent with Stenting	04/05/2010
<a href="#">R1926CP</a>	April 2010 Update to the Ambulatory Surgical Center (ASC) Payment System	04/05/2010
<a href="#">R646OTN</a>	VMS End-to-End Testing for HIPAA 5010	07/06/2010
<a href="#">R645OTN</a>	Version D.0 Inbound National Council for Prescription Drug Programs (NCPDP) Flat File Implementation	