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Health Reform Measure Passes Senate Finance Committee, 14-9

When the votes were in, it was thirteen Democrats and one Republican member of the Senate Finance Committee in favor of the committee's health reform bill, and nine Republicans opposed. As the Republican who voted in favor of the bill, Sen. Olympia Snowe (R-ME) was in many ways the focal point of the 5-hour hearing that preceded the vote.

"Is this bill all that I would want?" Snowe asked. "Far from it. Is it all that it can be? No. But when history calls, history calls. And I happen to think that the consequences of inaction dictate the urgency of Congress to take every opportunity to demonstrate its capacity to solve the monumental issues of our time."

Analysis by the nonpartisan Congressional Budget Office found that the Finance Committee bill over 10 years would reduce the number of uninsured Americans by 29 million. It would still leave 25 million people uninsured, about one-third of them illegal immigrants.

The bill is projected to cost $829 billion over the 10 years, which would be fully offset by new tax and fees, including a tax on high-cost insurance policies, as well as by savings from slowing the growth in Medicare spending by the government.

Use New Medicare Enrollment Forms by November 30

Practices must start using two new Medicare enrollment forms by November 30 or risk having these applications denied by their contractors. The changes apply to CMS-855I (for physicians and non-physicians) and CMS-855B (for medical groups and clinics). New forms have the revision date of "(02/08) (EF 07/09)" in the bottom-left corner. Contractors are instructed to accept older versions of the forms with "02/08" in the bottom-left corner until November 30. Contractors will now attempt to verify supporting documentation online in an effort to minimize the amount of documentation practices are required to send with the enrollment form. However, carriers may request copies of a degree or certificate when information cannot be verified through internet searches.

Downloads: The new CMS-855B, The new CMS-855I

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The bill will now head to the Senate floor for debate and a vote. It then must be combined with an earlier, alternate bill passed in July by the Senate Health, Education, Labor and Pensions (HELP) Committee.

Meanwhile, a new movement is afoot in the Senate to revive the public insurance option. Thirty Senators urged Senate Majority Leader Harry Reid in an October 8 letter to include a public option in health reform legislation. In the letter to Reid organized by Sen. Sherrod Brown (D-OH), 29 Democrats and one Independent wrote, "Opponents of health reform argue that a public option presents unfair competition to the private insurance companies. However, it is possible to create a public health insurance option that is modeled after private insurance – rates are negotiated and providers are not required to participate in the plan. As you know, this is the Senate HELP Committee's approach."

OIG 2010 Work Plan Includes New Audits Targeting Physician Practices

This year brought audits by the HHS Office of Inspector General (OIG) of physicians' place of service coding, incident-to services, facet joint injections and ultrasound testing.
If the 2010 OIG Work Plan is any indication, next year should be at least as active. The 128-page Work Plan lists close to 20 issues involving Medicare physician policy, including a number of new topics.

For example, OIG says it plans to study physician billing of transforaminal epidural injections (**64479-64484**). The watchdog agency says physician claims for these services grew 130% between 2003 and 2007. OIG plans to look at physician claims for the injections to determine whether Medicare payment was appropriate. "We will also determine whether there are policies and safeguards to prevent inappropriate payments for transforaminal epidural injections," the agency states.

Other issues OIG plans to study next year include:

- **Payment for services ordered or referred by excluded providers.** Because ordering or referring physicians are not required to be enrolled in Medicare, there are no safeguards in place to check whether these providers have been excluded from Medicare, OIG notes. The agency will check to see whether excluded providers have ordered or referred Medicare services, as well as "CMS oversight mechanisms to identify and prevent improper payments for services based on orders or referrals by excluded providers."
- **Medicare Part B payments for imaging practice expense (PE).** OIG will focus on such concerns as whether Medicare PE

Liability Reform Would Trim Total Health Bill 0.5%

Doctors have long lobbied for national liability reform. Now the Congressional Budget Office (CBO) has released its estimates, at the request of Sen. Orrin Hatch (R-UT).

CBO estimated the effect if there were a national cap on punitive and non-economic damages as well as other new rules that could limit doctors' liability exposure.

Such changes would lower the nation's total health bill by about 0.5%, or $11 billion a year at current spending levels, CBO states. That includes 0.2% from lower spending on malpractice, and 0.3% from "slightly less utilization" of health care as a result of less defensive medicine. CBO projects that, in all, the Feds would gain $54 billion over 10 years with a malpractice overhaul.

View the CBO letter here: http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf

payment reflects the actual expenses incurred and whether the utilization rate reflects current industry practices.

- **Medicare Services Billed With Dates of Service After Beneficiaries' Dates of Death.** For Part B services, OIG says, entitlement to payment for services ends on the last day of the month in which the beneficiary died. The agency plans to "review Medicare claims with dates of service after beneficiaries' dates of death to assess CMS's controls to preclude or identify and recover improper fee-for-service payments." This scenario tends to affect physicians for example, when diagnostic interpretations are rendered after a patient's death.
- **Many issues to be revisited from last year,** including E/M services billed during the global period, use of modifier GY, and payment for diagnostic X-rays in hospital emergency departments.

OIG defines its annual Work Plan as "the specific audits and evaluations that we have underway or plan to initiate in the fiscal year ahead," as well as the "general focus areas for our investigative, enforcement, and compliance activities."

Reference: HHS OIG 2010 Work Plan
http://oig.hhs.gov/08/Work_Plan_FY_2010.pdf

FDA Reveals 'Undue' Influence by Lawmakers in Approval of Menaflex Device

Some orthopedic practices could soon hear from anxious patients about the safety of their knee implants, after an announcement by the U.S. Food and Drug Administration that the device was approved for market last year after "undue" influence by four New Jersey congressmen and the FDA's own former commissioner.

A report in the *New York Times states:* The FDA's scientific reviewers repeatedly and unanimously over many years decided that the device, known as Menaflex and manufactured by ReGen Biologics Inc., was unsafe because the device often failed, forcing patients to get another operation.

But after receiving what an FDA report described as "extreme," "unusual" and persistent pressure from four Democrats from New Jersey – Senators Robert Menendez and Frank R. Lautenberg and Representatives Frank Pallone Jr. and Steven R. Rothman – agency managers overruled the scientists and approved the device for sale in December.

All four legislators made their inquiries within a few months of receiving significant campaign contributions from ReGen, which is based in New Jersey, but all said they had acted appropriately and

NY Health System to Subsidize Physician EHR Systems

North Shore-Long Island Jewish Health System says it will subsidize up to 85% of the cost of implementing and operating an electronic health records (EHR) system in the offices of its more than 7,000 affiliated physicians in New York City and Long Island, according to the American Hospital Association. The health system will subsidize either 50% or 85% of each physician's implementation cost and monthly operational fees, with a maximum incentive of $40,000 over five years. Physicians who receive the 85% subsidy will agree to use the EHR to report and share performance data. "We're not going to measure our return-on-investment in terms of dollars and cents; our ROI will be based on our ability to improve patient outcomes," said Michael Dowling, the health system's president and CEO. For more, click here.

were not influenced by the money. Dr. Andrew C. von Eschenbach, the former drug agency's commissioner, said he had acted properly.

The move to question the past conduct of a former FDA chief is unprecedented in the agency's history.

"The message here is that there were problems with the integrity of FDA's decision-making process that have solutions," Dr. Joshua Sharfstein, the agency's principal deputy commissioner, said in a conference call with reporters.

Dr. Sharfstein said that patients in the United States who had already received the $3,000 device should wait for the agency's review of the device's approval and urged them "not to panic."

Gerald E. Bisbee Jr., chairman and chief executive of ReGen, said that Menaflex was safe and described as "inaccurate" many of the agency's characterizations of the device's approval. Thirty patients in the United States and nearly 3,000 in Europe have received the device, and ReGen has trained up to 140 surgeons in the United States to use it. He defended the company's appeal to lawmakers.

"We did what people do all the time in Washington: we went to our congressmen, we went to our senators," Mr. Bisbee said.

Menaflex is a C-shaped pad used to repair a torn or damaged meniscus, the cushion between knee bones. A clinical trial of the device failed to show that it worked any better than routine surgery.

Reference:
The full New York Times report:
http://www.nytimes.com/2009/09/25/health/policy/25knee.html

FDA Review of the Regen MenaFlex:
http://www.fda.gov/NewsEvents/PublicHealthFocus/ucm183745.htm

Bill Would Exempt Small Practices from 'Red Flags' Rule

Physician practices with twenty employees or fewer may ultimately be exempted from the impending "Red Flags" Rule scheduled to be enforced beginning November 1.

A bill, (H.R. 3763) introduced October 8, 2009, in the House by a Democrat and two Republicans, would exempt small practices from the rules.

The Red Flags Rule requires businesses, including physician practices that offer credit to their customers (or patients) to offer an identity theft prevention plan by the November 1 deadline. The rule, enforced by the Federal Trade commission, requires practices to set up a formal, written prevention program to help identify, detect, and respond to patterns or activities – known as "red flags" – that could indicate identity theft among their patients.

Under H.R. 3763, some businesses, including physician practices with twenty or fewer employees would be exempt from having a Red Flags program in place. Additionally, practices that 1) know all of their patients personally, 2) only perform services in or around the residences of their patients; and 3) have not had any incidents of identity theft in the past, would also be exempt from the rules.

The new bill, sponsored by Reps. John Herbert Adler (D-NJ), Paul Collins Broun, Jr. (R-GA), and Mike Simpson (R-ID) is currently before the House Committee on Financial Services.

Reference: The Red Flags Rule.