

Part B Insider (Multispecialty) Coding Alert

Physician Notes: Is Medicare Hurting Your Business?

New survey reports disturbing numbers on Medicare impact

Anesthesia practices should keep their Medicare business to a minimum, judging from data in a Jan. 14 report from the **Medical Group Management Association**.

The more government health care business an anesthesia practice had, the higher the ratio of non-physician providers to physicians in the practice. The practices with the highest ratio of NPPs to doctors usually received 50 percent of their business from Medicare and other federal programs - and they tended to be smaller and less successful. The cost of NPPs as a percentage of a practice's total medical revenue more than doubled as the NPP-physician ratio increased, the survey said.

Low Medicare payment rates are forcing a staggering 86 percent of anesthesia practices to accept a stipend from their local hospitals. Practices with less than 30 percent of revenue from government health programs reported median revenue that was nearly \$10 more per base unit of work than practices that received 50 percent of revenue from government payers.

To read "Cost Survey for Anesthesia Practices: 2004 Report Based on 2003 Data," go to www.mgma.com/press/anesthesiacost.cfm.

1. **Transmittal 100, dated Jan. 21, says carriers and other contractors** should consider all documentation that you provide to determine if an item or service is medically necessary. In other words, they won't just look at the medical records. They'll also consider physician letters, physical therapy/occupational therapy evaluations, and other documents - even if providers created the documents after the fact.
2. **Transmittal 95, dated Jan. 14, says that from now on**, when a provider appeals an enrollment decision (such as a denial of enrollment or re-enrollment), the appeal will go to an Administrative Law Judge. In the past, these appeals went to the carriers. The ALJs, which used to be under the **Social Security Administration**, are now part of the **Dept. of Health and Human Services**, giving HHS more control over their decisions.
3. **A proposed rule from CMS would revamp quality standards** for 4,700 renal dialysis facilities for the first time in nearly 30 years. The "patient-centered" rule, in the Feb. 4 Federal Register, includes updated infection guidelines and instrumentation requirements for water quality and hemodialyzer reuse; inclusion of defibrillators in the emergency-equipment list; modernized fire safety code provisions; public posting of external and internal patient grievance mechanisms; and comprehensive assessments and patient plans of care better geared toward organ transplantation.
4. **CMS finalized plans to expand coverage for implantable cardioverter defibrillators to new populations**, including patients with heart failure, poor function of their left ventricle, or a "narrow QRS" finding on their electrocardiogram. CMS proposed the expansion last fall (see PBI, Vol. 5, no. 36).