New Physician Training
(60:00)

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Hello, I'm Valerie Hart, director of division of provider information planning and development at the Centers for Medicare and Medicaid Services or CMS.

More simply, my colleagues and I provide the national leadership for the Medicare learning network.
The Medicare learning network combines the efforts of CMS central and regional office staff as well as the customer services representatives and provider educators at your local Medicare carrier or intermediary.
Together we help Medicare billers navigate the complexities of the Medicare program.

Joining me today are two of the many practicing physicians that work at CMS.
Doctor Hugh Hill is CMS's medical officer, and Doctor Scott Young is our senior clinical advisor.
We'd like to welcome you to the Medicare program.

As residents and new physicians you are probably among many in the medical community who may view Medicare and all it's requirements, the paperwork and administrative duties and an insurmountable obstacle to practicing medicine. Sadly, that's a very common first impression.

You know in 1992 I was doing my residency in Fairfax, Virginia, and that's exactly how I felt. Even today I can't deny that Medicare is indeed a complex program. But with America's aging and disabled population rapidly increasing, learning all you can about Medicare today is more of a necessity than an option. Your practice may likely depend on it and we're here today to help you get started on the right foot. Today's satellite broadcast was designed with you, the finishing resident or new physician in mind. It's a product of the Medicare Learning Network which is a comprehensive provider training and education program designed to bring you and your office staff, what we like to call, just in time information about Medicare.

Available 24 hours a day, 7 days a week. Medlearn is the homepage of the Medicare learning homepage at CMS. Medlearn and the other provider specific pages found on the CMS web site bring you valuable resources such as open door forums, free web based training, educational publications, and satellite broadcasts. Education is your ticket to future peace of mind, so let's get started by welcoming you to the Medicare program.

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The Centers for Medicare and Medicaid Services, or CMS, administers Medicare, Medicaid and the State Children's Health Insurance programs for more than 75,000,000 Americans each year. To serve so many beneficiaries and the hundreds of thousands of physicians, providers, and suppliers who bill Medicare, CMS is dedicated to creating and maintaining a culture of responsiveness to all our partners in the Medicare program.

In 2001 we embarked on a campaign of reorganization and reform within this agency to improve communication, education, and the management of our programs and we've come a long way in accomplishing these goals by making ourselves more accessible. Here are just a few examples.
Internet access to our cms.hhs.gov/Medlearn, and the other helpful provider information pages provide information on virtually all subjects concerning Medicare and other CMS programs.

We continue to provide training for our residents and physicians through the Medicare Learning Network.
In addition, changes in Medicare rules and regulations are easier to track through the CMS quarterly update now available by email. Our culture of responsiveness includes new channels for physicians to reach us with questions or suggestions such as Open Door Forums and advisory committees. A way for our beneficiaries and physicians to voice their concerns, providing CMS with the knowledge we need to improve our services, and we've developed the National Standard Survey that helps us gather information directly from the patient regarding their hospital care experience with the intent that we will improve that experience, and finally our Quality Improvement Organization Program works with physicians to improve the quality of care.

There's much more, but the bottom line is we want our beneficiaries to receive the best care. We want to simplify the lives of physicians and all those who participate in the Medicare program, and we want quality service to be the number one priority in this agency. Here's more about CMS and our role in the Medicare program.

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Inside the CMS headquarters building in Baltimore, Maryland where decisions about national program direction are made, and at 10 regional offices around the country where a local presence provides customer service and oversight, more than 4,000 CMS staff members work at maintaining and improving program quality and effectiveness.

In partnership with state agencies, physicians and other practitioners and the insurance companies whose example and involvement have been vital to the programs, they ensure that Medicare, Medicaid and S Chip are efficiently operated.

Through a public rule making process and in collaboration with independent experts like the practicing physicians advisory committee and the Medicare coverage advisory committee, they develop, evaluate, and modify program policies and procedures.

As part of that effort, CMS conducts ongoing research on the cost and effectiveness of comparative methods of health care management, treatment, and financing, and assesses the quality of health care facilities and services.

As part of its oversight and enforcement responsibilities, the agency works with the justice department to curb program fraud and abuse and since 1988 has regulated all non-research related laboratory testing on human beings in the United States.

Under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, CMS, together with the Departments of Labor and Treasury, helps millions of Americans and small companies get and keep health insurance coverage regardless of changes in their employment, geographic location, or health status. HIPPA touches almost every aspect of health care today. HIPPA established a process for the public and private sector to work together to establish standard formats for all electronic health care transactions. HIPPA privacy and security provisions provide for national standards for protecting your patients' confidentiality, safeguarding your office systems, and your communications with health insurers.
Through all of these efforts CMS and its partners strive to sustain and further the commitment to the millions of Americans that rely on the Medicare, Medicaid and S Chip program.

Through the Medicare, Medicaid and S Chip programs, our nation acts as its own largest and most economical health insurer dispersing over $500,000,000,000 each year. Medicare alone provides reimbursement of over $250,000,000,000 to hospitals and providers.

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Medicare is the nation's largest health insurance program covering nearly 40,000,000 Americans. Those who are eligible include the aged insured, or individuals aged 65 and older. The disabled insured, or individuals who have been disabled for two years, and individuals with end stage renal disease requiring either a kidney transplant or dialysis. Entitlement to Medicare is based on working under social security, meeting requirements for age or disability, and in many cases payment of a premium.

Medicare actually consists of three parts.

Part A is hospital insurance. This helps pay for inpatient hospital services, skilled nursing facility services, certain home health services and hospice care.

Part B is supplemental medical insurance which helps to pay for doctor services, out patient hospital services, certain home health services and medical equipment and supplies.

Part C or Medicare plus Choice, as it is called is a set of health care options created by the balanced budget act of 1997.

Options include health maintenance organizations, point of service options, provider sponsored organizations, preferred provider organizations, Medicare medical savings accounts, private fee for service plan, and religious fraternal benefit society plans.

Health care spending in America has increasingly become the job of the federal government. About one in three health care dollars is a federal dollar. But CMS doesn't actually pay these claims, they are contracted out to private companies. To better understand this process let's turn to the comments of Doctor Bill Rogers. Recently he met with residents and new physicians at the George Washington University Medical Center.

I'm Bill Rogers, I'm an ER doc, work for the Medicare program and mostly what I do or a good part of what I do is go around to talk to physicians. We process about a billion claims, a billion claims a year. We actually don't pay claims, we, CMS, contract with insurance companies and the insurance companies that pay the part A plans that pay the hospitals are called intermediaries, and the insurance companies that pay the part B claims that pay the doctors are called carriers.

There are also DMERCS, and DMERCS pay for durable medical equipment which is wheelchairs, crutches, splints, things like that, and then we of course have a bunch of policies that have to do with how we carry out the transaction, we have national coverage decisions, we've got diagnosis related groups which are priced, outpatient fee schedule and the physician fee schedule. Then the carriers also have their local medical review policy and carrier prices.
There's a trend going on right now that more and more of these decisions are being made by CMS rather than by the carriers, but the carriers have their own authority to make some rules on their own. If we hadn't made rules which are controlling.

Okay, now there's local policy that I mentioned before. Each carrier has a carrier medical director, the carriers of the insurance company that pay the part B claims. They have things called cac's which are committees of physicians, you might be on a cac at some point who help the carrier medical directors make local medical review policies, MMRP's.

If we have an NCD, a national coverage decision then that is controlling, but in the absence of national coverage decisions carriers will often will produce local medical review policies. These are the things that drive you nuts, that say, you know you can't order a certain lab test unless the diagnosis is there, or you can't order a cat scan unless the patient has the following 25 diagnosis. Those are often local medical review policies. There is the right to request a review of a policy like that, which is actually we have provided very strict rules about that, and the carrier has to review the policy if the physicians disagree with it. If the physicians are still not happy with the carrier's decision then they can request that CMS do a national coverage decision.

The carrier advisory committee is a great way for a physician to influence how Medicare works locally
These committees are composed of local physicians and make recommendations to the carriers on their local policy. I've worked with local carrier and advisory committees, or cac's all over the country and at the national level with the Medicare coverage advisory committee and I can tell you with certainty these are a great way for our physicians and for our carriers to communicate any concerns.

The number one CMS concern, of course, is accurate billing on the part of the physician. For physicians and providers the top issues year after year are related to patient eligibility for Medicare and denial or delay of payment. More often than not these concerns or questions are expressed by office staff using CMS toll free lines to reach their local carrier or intermediary. Of course getting an answer is only half the battle. You still have to work through a solution in your office. Even a small office has a variety of functions related to billing. These functions include incorporating the information into the medical record, assigning codes or diagnosis and procedures, preparing bills, and following up on delayed or denied payments, usually called collections.

To get a better understanding of just how accurate billing effects reimbursement, let us introduce you to Doctor Rosa Fernandez. Doctor Fernandez is new to her practice and many of her claims have come back from the carrier as

rejects. Since most people don't want to go on television and talk about what they did wrong, we hired actors to explore a fictitious conversation that might become real to you after you begin your practice. Let's listen now as Doctor Fernandez discusses her predicament with Mary from her billing office.

I'm embarrassed because I just learned that I'm responsible for a lot of Medicare rejects.
Can you give me a crash course in Medicare so it doesn't happen again?
Of course, I'm sure we can get it all straightened out today so you won't have any more problems.
Now, Doctor Horn asked me to look at the claims that were rejected, and many of them were sent back for documentation that services were medically necessary.
I wouldn't have done them unless they were medically necessary.
I know that, but you have to document the patient's condition.
You have to indicate why you performed a specific test or service based on the patient's signs, symptoms, or complaints.
Now you know that we purchased cardiac equipment to improve the service to our cardiac patients.
Well we really have to code these procedures correctly.
Now you look at this claim here.
You ordered an EKG.
Yeah, I remember that patient, he was having chest pain.
But you didn't circle the code for an EKG on the super bill, so we never billed for it.
We noticed it when one of the billing clerks looked at the record after his next visit.
Well here I performed an exam and ordered the EKG to follow up.
That doesn't tell you much does it?
No it doesn't and since we didn't bill for it Medicare didn't reimburse us for that procedure.
We can still submit a claim but we'd rather get it right the first time.
Now you can help us do that.
We make it easy for you so it doesn't take up a lot of your time.
All you have to do is circle the appropriate sections on the super bill.
Now here's another example, you ordered a Doppler echocardiogram for Mr. Cannon.
Yes, I remember he had shortness of breath and chest pain.
The only symptom you indicated on the super bill was shortness of breath.
Now if the patient only has shortness of breath Medicare will only reimburse us for the echo.
But we looked into the record and noticed that he also had chest pain.
When we list both symptoms, Medicare reimburses us for both the echo and the Doppler.
Mary I don't want to cause problems, but caring for my patients takes up all of my time.
I can't seem to find the time to jump through the hoops that Medicare puts on me.
I know that time is a problem, but when you don't make time we lose revenue.
Okay.
I can see that I could have caused the practice some revenue in these cases, but they can be fixed can't they?

They can, but it's time consuming. When you don't circle the appropriate visit codes on the super bill we have to go through the records, read your notes, and try to figure out how the visit should be coded, and sometimes the records don't contain enough description for us to accurately report the highest level of a CPT code, even if that's the level of service that you performed. We'd rather play it safe so we under code rather than over code our claims.
And when we don't know how much time you spent with a patient, for example, we estimate on the conservative side. That means our reimbursement is probably a lot lower than it should be, and that effects all the doctors here, and on top of that when the claims are filed incorrectly reimbursement is delayed and the practice occurs additional administrative expenses when we resubmit them.

Well I didn't know that.
And remember when you joined the practice you signed the form reassigning your benefits to the group?
Vaguely, yeah I signed a lot of forms.

Well all of our physicians sign the same agreement. Medicare sends reimbursement to the group and our physicians receive a portion of our net income. When we get less money than we should or our payments are delayed it effects their income as well as yours. So we really need you to help us code appropriately to maximize our reimbursement.
And there are other times we need your help as well.

When?

Sometimes we need your expertise when Medicare or other insurance carriers request more information about services that you performed in the office or hospital. Now typically they ask for additional documentation that supports the medical necessity of a claim of service before they process the claim.

That doesn't sound too difficult, but they really should change our job descriptions, "Doctors wanted, must have medical and clerical skills and athletic prowess."

Very funny.

Seriously though, it's not just Medicare you're having trouble with. Those were just the claims that came back yesterday. Now these rejects are from other health plans we participate with. Now you have a high reject rate with all of them because virtually all health insurance use the same claim forms and have similar requirements.
Now this can be a major problem.

So what you're telling me is there's no way around this stuff.
There isn't.
Today physicians have to do more than medically treat their patients, they also have to play a more active role in billing.

Well that's obviously how we hope a situation like that will turn out, but we know that there may be misunderstandings. That's why while it is ultimately the physician's job to make sure a patient's care is properly documented, it is also important that they have a well trained and experienced staff that understand the ins and outs of Medicare's requirements. They are the last ones to see a bill before it goes to Medicare. It's also important to note that the Medicare program wants to pay its fair share and we determine that payment based on the bill the physician submits, and ultimately what is in the beneficiary's medical record.

You may have wondered about the super bill that Doctor Fernandez and Mary mentioned.
In many offices physicians and practitioners use something called a super bill.
In your office it may be called a charge master.

These are locally developed forms that are really memory joggers for clinicians. A good one focuses on the services and procedures that your practice bills most often. The super bill helps the physician work with local medical review policies and identify information that must be present in the record to support the bill they send. Many of Medicare's policies and requirements are based on the evidence we used to determine Medicare coverage. In short, Medicare's complexity is driven by the complexity of health care. And it can be complicated. It wouldn't surprise me if our viewers were asking themselves why they'd want to participate in the Medicare program.

Well, as we said earlier, a physician's practice may depend on it. There are many benefits. So in our next segment let's look at these benefits and requirements of participation.

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Medicare allows any licensed physician or part B provider who has met Medicare's enrollment criteria to bill the Medicare program. Physicians can also elect to be participating Medicare physicians. A participating physician agrees to always except the reimbursement amount set by Medicare while non-participating physicians can choose to accept the Medicare payment amount and collect the small additional fees allowed by Medicare.

What are the advantages of participation?

One benefit of participation is that the Medicare fee schedule allowances are 5% higher than allowances for non-participating providers. A fee schedule is a complete listing of fees used by a health plan to pay doctors or other providers. Participating physician's are listed in directories that cost conscience Medicare beneficiaries consult

when they are looking for a physician. For a new physician a listing in the Medicare participating physician directory, Medpard can help you build your new practice.

Even if you elect not to become a participating physician, you're still bound by provisions of the Medicare statute to file a bill on behalf of your patient and there are limits on what you can charge a Medicare beneficiary. Even if you do not participate you can, on a case by case basis accept assignment. In other words, accept the Medicare payment amount minus co-insurance and deductibles, as payment in full. In fact in accepting assignment one of the advantages is that you can charge what you want to, but if you don't accept assignment then you are limited to charging only the amount in the fee schedule and I think you only get a reduced amount. The reduction is not much, maybe 5%, but that's one the differences in accepting assignment and not.

Because participation is an annual decision you can always change your mind next year if participation isn't a good option for you. During the annual open period you can change your mind and reverse from participating or not and visa versa. So as we sit here and tape in the spring of 2003, CMS and congress have just finished a major adjustment to the physician fee schedule to compensate for the unanticipated effects of a softening economy.
The lesson of this year's effort is that it always makes sense for a physician to review the new fee schedule and elect to participate or not participate based on the most recent information.

That fee schedule is changed annually on what I understand is the basis of a statutory formula.
Is that right Scott?
Well that's exactly right.
You know it would literally take an act of congress to change that.

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The Medicare physician fee schedule establishes payment policies and payment rates for over 10,000 procedures that are performed by physician and certain non-physician practitioners such as nurse practitioners, physician assistants, and physical therapists. Physicians are paid through a fixed fee schedule based on the procedure code submitted to Medicare which correlates to a specific service. For each type of a physician service, from the simplest office visit, to complex surgical procedures, the fee schedule assigns a number of RVU's or resource based relative value units intended to reflect the resources involved in the service.

These resources include the physician's work involved, practice expense, and malpractice insurance.
So what we're saying essentially is that different procedures have different codes and that a procedure code lets Medicare know the amount the physician will be reimbursed for that service.

Yes, and physicians can determine what code applies to which service by consulting the CPT book which is available from the AMA, the Medicare fee schedule which is available online from CMS, Medicare manuals and bulletins describing Medicare coverage policy, and billing requirements, commercial training or software, and there's free training from the Medicare Learning Network.

While a toll free call to a Medicare customer service representative can help explain Medicare policy to you, they're not coders and they can not see your medical record. They've been instructed to resist the temptation to give you coding advice about a particular case over the phone. When CMS and its contractors look at a bill they look at each service based on the diagnosis code. Normally we wouldn't expect a craniotomy, for example, for a patient who presents with, say a broken ankle. They also look at how the procedure codes relate to each other.
For instance, if a surgeon begins a laproscopic cholecystectomy, but runs into trouble and has to convert the procedure to an open one, we would only pay for the open cholecystectomy.

I see, okay Ralph.
You know usually we have enough information on the bill to make a payment decision, but sometimes we delay our decision while we ask you for more information from the medical record. It's important to pay attention to these returns since the delay can turn into a denial if you don't respond. It's always a good idea to open the mail you get from CMS and it's carrier's intermediaries.

One of the most important pieces of mail you will get each year is what CMS calls the annual "Dear Doctor" letter.

This is the letter that lets you know what's changed on the Medicare fee schedule, explains how the new rates were calculated, and offers you the opportunity to elect to become a participating physician.

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While the paper UV92 and the CMS 1500's still exist as paper bills, almost everyone who bills Medicare uses electronic billing. The administrative simplification provisions of HIPPA established two formats for electronic billing. The 837I for the institutional part A and B billing sent to intermediaries, and the 837P for the professional billing sent to carriers by physicians, practitioners, and suppliers. Electronic billing is usually called electronic data interchange, or EDI.

What does it take to bill electronically?
You can use commercially available billing software that works with your office systems or that is a part of a bigger office system, or you can hire a billing service or clearing house to bill for you, or send the bills you prepare to the right health insurer. Your local carrier or intermediary can give you a list of billing software or services who have tested with them. After October 16th, 2003 almost everyone who bills Medicare must submit those bills electronically.

Doctor Young and Doctor Hill what are some of the advantages even for small billers to submit electronically?

Valerie, one of the first advantages is you get your payment quicker, in almost half the time. In a period in which we allow people to submit paper claims to Medicare, we didn't require the contractors to get the checks back out the door to the providers within the same short timeframe. Now everyone who bills electronically will be getting the money quicker and if you're a physician who's just starting a practice you already know, and if you're a resident just finishing you'll soon know, how important the length of that pipeline between providing the service and receiving the check is.

Another thing is your remittance advice. That's the advice you get from Medicare why you got paid what you got paid and maybe why you had a claim denied, that comes electronically as well. And as Doctor Young said, it's that remittance advice that tells you why we did what we did and why you need to send us more information. Sending your medical records in is one form of compliance, but let's talk about other compliance issues.

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Compliance programs in all aspects of the Medicare program demonstrate a physician's commitment to legal and ethical conduct. This is perhaps most notable in areas of payment accuracy which is defined as paying the correct amount for a covered service provided to an eligible beneficiary by an enrolled physician. To ensure payment accuracy physician's must understand billing codes and ensure their staff understands then as well, and physicians should regularly review claims filed on their behalf by billing services to ensure correct billing for the services rendered.

To better ensure their office's comply with Medicare's requirements, physicians should maintain sound business relationships. This includes entering into contractual agreements with others carefully and being familiar with Medicare's requirements. Having a compliance program doesn't provide a physician or other organization with immunity from scrutiny or corrective action. And unfortunately incidents of fraud and abuse in the Medicare system do exist and can result in fines and or criminal or civil charges.

Let's begin by taking a look at some of the things that physicians need to know to submit accurate claims, and I believe proper documentation leads the list here.

Doctor Young, we've mentioned that Medicare wants to pay physicians for the services they perform, but simply can not pay for services that aren't correctly documented in the medical record.
Can you give us your perspective on that please?

Doctors must be familiar with Medicare requirements. It also helps to have a knowledgeable staff. Many offices, for example, staff will pull a sample of bills and review them against the medical record. Much the way CMS and

its contractors would do. However a physician is ultimately responsible. Having said that it's important for the physician to look at what their practice sends Medicare. It's also important that the physicians look at the remittance notice that Medicare sends back that tells you what Medicare paid, reduced, or denied. These notices contain explanatory codes for every action that was taken on the claim.

Hugh, can you explain some of these explanatory codes?
I know some of these concepts, like medical necessity and bundling can get pretty complicated.
Can you give us the big picture definition?
Sure.

These codes describe all sorts of payment and denial actions. Some denial codes that physicians may see include excluded services, bundled services, or services that aren't considered necessary medically. Excluded services are services that Medicare never pays for, such as routine physicals, examinations to prescribe a hearing aid or glasses, or cosmetic services.

Bundled services are services that are included in the basic allowance of another service and they're not covered by the Medicare program. For example, supplies included in the basic allowance of another procedure. You could also see a denial for services that aren't medically necessary. These are services Medicare determines are not medically reasonable and necessary for the diagnosis and treatment of an illness or injury or exceed the Medicare usage limit.

An example of this type of denial is performing more diagnostic tests than needed to determine a patient's diagnosis. Over payments are an important fact of life for Medicare and drive a lot of decisions we make in the program about how we're going to try to control spending. In a huge program like Medicare even a small percentage of overpayments can be an enormous amount of tax dollars that are wasted. So whether the overpayment is caused by you with your mistake in billing, or us with our mistake in payment, we have to get the money back, and we have to identify those. In some cases if you're doing the audit that we talked about, if you're checking your own practice you may discover that you've been overpaid, or learn that you've been, by following a procedure in your office, overcharging Medicare. It's your obligation to let us know and return the money. In other cases we'll discover that there's been an overpayment and then we will ask for prompt return. Returning the incorrect payments avoids additional fees and interest rates. So when that comes up you'll need to talk with your carrier immediately and straighten it out.

Now sometimes you'll be contacted by your carrier asking for more information with regard to a certain claim.
It doesn't mean the claim is being denied, it just means that we need more information, so don't panic, just provide the carrier with the needed information. Many people are surprised to find that certain preventive services are excluded as well. In 1965 congress specifically excluded preventive and screening services from Medicare.
In fact Medicare is limited in what it can pay for by law and the law says payments for those services that are considered to be reasonable and necessary with the diagnosis or treatment of an illness or injury, or to improve the function of a malformed body part. And that's why, for instance, we can't pay for diabetes screening for patients who have no symptoms of diabetes, however there are some exceptions.

Since 1965 Medicare has added immunization for flu, pneumococcal pneumonia and hepatitis B, diabetes self management benefits and a schedule of cancer screening for men and women. We also mentioned business relations. If you use commercial billing software or work with a billing service it's very important that you understand how to make the changes or updates needed to comply with Medicare changes. Your local carrier and intermediary can help you find software vendors or billing services that have tested with them and can help you stay current with Medicare requirements.

We can't talk about compliance without addressing non-compliance, which is something that can result in accusations of fraud or abuse. While the terms fraud and abuse sound like they may mean the same thing, they are actually very different. You know Valerie that the terms fraud waste and abuse actually come from the offices of inspector General that exist across the government. When the department of health and human services fraud waste and abuse have to be applied to the health care arena.

Within Medicare we make a sharp distinction between fraud and mistake or error. Fraud worries all physicians, and while the numbers of actual cases of fraud prosecution are very small every year, that number is still a concern both

to established and new physicians. In fact I think the numbers in the last few years have been less than one thousandth of one percent of practicing physicians who are actually brought up on claims of fraud, and yet as physicians we are accustomed to worrying about and to trying to avoid rare disastrous events.

So we do think about these things.

The important thing to remember about fraud though is that fraud requires knowledge or intent. So if you don't intend to defraud or steal from the government you are not going to be accused of fraud. Now error comes under the category of perhaps waste or abuse. And error can also be quite simply honest error without any intention to make a mistake. But in those events where there's error, either on our part or on your part with your billing we do have to get the money back, the statute requires us to do that.

We've covered a lot of ground so far. I know it seems like a lot to manage, it may even appear overwhelming. But here's something to consider.

There are nearly a million and a half physicians and providers in our country that serve Medicare beneficiaries. So billing accurately, staying on top of Medicare regulations, maintaining compliance, and all that goes with articipating in the Medicare program can be done and is done every day. For a personal look at how two physicians balance the care of their patients with the requirements of Medicare let's take a brief trip to rural Louisiana where doctors Elizabeth Doze and Sam Abshire have set up practices about 20 miles apart.

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Northwestern Louisiana is a place of lakes and bayous. Small towns, and rural countryside. It has a disproportionately high population of elderly and low income residents. For family practitioner, Doctor Elizabeth Anderson Doze, the day often begins with rounds among her patients in local rehab and nursing care facilities.

Hi Marilyn.
How are you!
Follow up care may require her to visit several facilities spread over many miles.
Okay, we're off to the next stop.
Because of their age or limited resources many patients have no reliable means of transportation, so today she'll also make a house call to a client unable to pay for the 70 mile round trip to her clinic in Mendon.
Okay.

[knocking]
Come in.
I'm at the right house huh?
You look good!
Okay.
The rash is cleared up, let me see your feet.
You look good.
You look better than when I saw you up at the rehab, you really do.

Back in the office Elizabeth settles in for her daily ambulatory patient visits. She has a large private practice that is 70% Medicare and Medicaid served by herself and nurse practitioner Sally Bethea. It's really tough to have a practice with this many patients that are Medicare and Medicaid only because you know you tend to get reimbursed at a lower rate. But there is still that need out there for these patients to be seen. You really have to know what you're doing, and if you don't know what you're doing or I don't for the most part you need to have somebody that you can rely on that you can trust that will do your billing for you that's not going to do things to get you in trouble. The biggest thing, the most important thing a physician can do is document, you know you need to document appropriately and make sure that whatever you diagnosis you end up giving the patient you can back up in their progress notes in the medical record.

To help handle the workload and maximize reimbursement while ensuring compliance, Elizabeth relies on a billing service and a dedicated staff with a team focus.

The more staff that you have that you can use to help support the things you do, the more it does take the load off the physician. You only have a limited number of time slots per hour to be able to fill to treat patients. And you need to be able to make the best use of that time as possible. By the time a patient gets to me, the receptionist has already checked to make sure that they're still within their allotted number of visits. If a referral needs to be made to us from another physician, the receptionist has already gotten that accomplished for me.

To make sure that patient documentation and billing claims stay in agreement, Regina routinely conducts in house audits. The office manager randomly, probably once every seven to ten working days will pull either mine or Doctors Doze' super bills before they're sent to billing and she'll pull all the charts that we've seen for those patients that day and will look at the bill based on what we've written in the chart, what our dictation is to make sure that we've billed appropriately for that level of care. Basically you have to have support for the coding, protect yourself and protect those around you by having good systems in place.

I don't think that you can stress enough the importance of education and communication.
I don't think you can stress enough the importance of good documentation, because if it's not documented it didn't happen.
If it didn't happen, then you don't get paid.
Hi Mrs. Manson.
There you go.
Thank you.

Basically you can get into trouble by not getting enough reimbursement, by not knowing what you're doing in terms of submitting forms to insurance companies so you can get claims paid to Medicare or Medicaid. If you get a reimbursement that's 60 to 70% or higher, you're doing very well in family practice.

About 20 miles north on highway 79, just outside Houma, Louisiana, Doctor Sam Abshire has found a different solution to his patient's problems with transportation and access to specialists. He's created a central location where he can provide many more on sight patient services including x-rays, bone density scans, and lab work analysis. He has facilities for in clinic specialists to visit on a regular schedule.

I'm going to examine your chest and ears and what not and we're going to get that dexascan like you had back in '99.
Rural populations are not a mobile population.
Rural patients are not mobile.
I will have to have them share with me, "Well doctor I don't know if I can come back for this follow up next week because you know it cost me $10 to get here this morning."
And when I first came to practice and I heard that, we don't have taxicabs and we don't have public transportation, people are expected to and do pay their relatives, their neighbors, their friends, to transport them for health care services.
If they have to pay $10 to travel 6 miles what would it be to try to get to Shreveport which is 60 miles away and spend a whole day?

Those are the issues that we deal with as practitioners in this rural community. The practice also recently joined with others in the Shreveport area to consolidate efforts and to provide centralized billing. This clinic was built and it's administered by a large hospital system out of Shreveport, Louisiana. They're a 501C3 corporation, a not for profit, and to our benefit and more important to the benefit of the population they're sensitive to the needs of under served areas and under served populations. Thirty minutes apart.

How long they been going on?

The fiscal burden of the physical plant as well as the administrative burden, the overhead and whatnot, does not lie directly on this physician's shoulders.
You know that risk is spread.
So having said that that gives the population in this community some security that we should be here for a long time.

While their approaches to the delivery of care may differ, successful practices like those of Sam Abshire and Elizabeth Doze rely on following the same basic requirements of Medicare and Medicaid carefully.

It's important to note that regardless of whether you practice in an urban, rural, or suburban setting, one thing is for sure. The requirements of participation in the Medicare program are going to be the same. And those requirements are a challenge, no one denies that. But we're all working together to make things better and easier.

[music]

The Centers for Medicare and Medicaid services long recognize the important role of the public and expert involvement in its decision making process. That's why CMS has made great strides toward improving the channels of communication between our providers, our beneficiaries, our contractors, and all our Medicare partners. Today we are more accessible than ever before.

Perhaps nowhere is that spirit of openness more noticeable than in the agency's open door forum initiative. This initiative includes 12 monthly and bimonthly open door forums as well as several special forums. Each focuses on issues specific to Medicare and Medicaid and each is chaired by a senior level agency official and co-chaired by a CMS regional administrator. In addition, our advisory committees provide advice and recommendations in such areas as physician services, proposed medical coverage, beneficiary education, and management.

Our committee members reflect a balance of viewpoints, education, and experience. Members include physicians, pharmacists, providers of service, and other experts. One of our biggest successes in reaching out to physician and other providers has been the creation of the CMS open door forums. Some forums cover the issues that matter to specific provider audiences, like nurses, physicians or health plans. While other forums look at crosscutting issues such as rural health and diversity.

Hugh, you've had some experience with the forums, can you tell us about that.

Yes Scott, I've had the privilege of participating in these forums and I can tell you that they've been a wonderful innovation, they speak worlds about CMS's desire to be open and to communicate with the customers and business partners we share responsibilities for serving beneficiaries with. They've been very, very well received by the communities that are reached out to by the various forums. We've gotten very, very good feedback on them, in addition to the feedback we get during the process itself. They've been a real success for CMS and we hope that we'll be able to continue them, and they're something that the physicians who are new and just starting practice should especially try to participate in.

Thank you.

If you want to participate you can watch for the notice that proceeds each forum in the federal register. Check the CMS homepage regularly, join one of our forum specific list serves, or subscribe to the open door forum online newsletter. If you missed the live open door forum teleconference you can still call in and hear it on tape for up to 48 hours after the forum.

I've also had personal experiences Scott with another form of advisory committee, the Medicare Coverage Advisory Committee is a national committee and there are other committees that CMS and the Department of Health and Human Services have to advise us in our work and to get input from the practicing physician community. That's vitally important to us. So if you're interested in becoming a committee member of that sort, please be aware that new members are selected annually. You can check in the federal register for those announcements as well.

What's in it for you, being involved in these, is your chance to expand your influence and give your input and your experience and you can qualify simply as a practicing physician enrolled in Medicare. The time commitments for these various committees are varied, some of them meet once a year, some much more often, and the amount of homework required before and after each meeting can vary as well. So you can probably find one that suits your schedule, your availability, and hopefully your interest.

Again, visit the federal advisory committee act, or FACA, F-A-C-A page on CMS's web site for more information on how to apply.

You may remember earlier in the tape Doctor Bill Rogers mentioned in the George Washington University listening session, there are lots of opportunities to work with your local carrier or intermediary on a variety of local committees that address coverage, local medical review policy, and provider education. In our next segment we'll look at a way that you can make even more of a contribution by working here at CMS.

[music]

CMS's effectiveness in managing its large and important programs depends on the capabilities of its staff. The agency places high emphasis on attracting and developing skilled dedicated professionals. CMS can offer some of the best assignments in the federal government such as working on important national issues, solving mission critical operational and administrative problems and being part of a dynamic fast paced and highly visible organization.

Employment opportunities at CMS include openings at our Baltimore headquarters and at our 10 regional offices across the nation. New career opportunities are posted on the CMS web site everyday as well as information on benefits and how to apply. Contact CMS for more information about our special hiring authorities such as student programs, the federal career intern program, and selective placement.

When I first came to work at CMS there were only a handful of physicians who worked here. Now there are dozens of physicians working here and we're recruiting more all the time. When I attended the listening session at George Washington University with Doctor Rogers one of the best parts of his presentation was titled, "How I came to be working for the enemy."

Hugh, Scott, what would you say to a new physician who is thinking about working here at CMS?
Well I'd have to encourage them.
One of the things that brought me was the ability to take experiences I'd had in practice, teaching residents, and other activities and bring it here to bear on some of our policy initiatives including quality, patient safety, payment policy and other things.

Hugh?

I went to law school after medical school so I've had a career long interest in health policy, but I've only been at the agency for about three years having come out of an academic medical environment and I can tell you the thing that's impressed me the most since being here is the sincere good intentions of the thousands of employees that this agency has and their desire and willingness to listen.

I've had an incredibly varied experience and I've been privileged to work on such things as regulatory reform, coverage, program integrity, and now Medicare as a secondary payer. The lesson for me to take back to practicing and starting physicians is that whether you're going to work her immediately, interested in working here potentially in the future, or never work here at all, is pay attention.

What we do effects your practice and we do want to listen and your input's important to us.
Our parent agency, the Department of Health and Human Services is also a great place to begin a career in public service.

[music]

We hope that in this hour we have given you some of the basics of Medicare and the tools to learn more. If there is just one thing that Hugh and Scott and I can share today it would be the commitment CMS has made to making the most successful healthcare program in the country even better, and that means improving the health, longevity, and quality of life for our older Americans and others. Whether you're a finishing resident or new physician, one of the intentions of this program is to impress upon you the importance the Medicare program will play in your practice.

America's aging population has increased and according to current trends the number of people Medicare serves will nearly double in the next 30 years. Chances are you will be treating Medicare beneficiaries and the more you know now the better off you'll be in the future. It is our aim to set you up for success.

For over 6 years CMS has provided comprehensive provider training and education programs. Today's satellite broadcast is just one example of that. We encourage you to continue to educate yourself about Medicare through the Medicare Learning Network and all the resources we provide. We hope we have given you some of the tools you need to become a lifelong Medicare learner.

If you have comments or questions about this or any other product from the Medicare Learning Network at CMS send us an email at medlearn@cms.hhs.gov.

Until next time we wish you all the success and satisfaction that comes from patient care. For Hugh and Scott and all of us at CMS, thanks for watching.

[music]