

THE PHYSICIAN'S COMPLIANCE ALERT™

PROVIDING PHYSICIANS WITH MEDICAL PRACTICE COMPLIANCE SOLUTIONS

What You Need to Know About the Medicare Modernization Act

Most likely, your patients are already talking about the new Medicare drug benefit—the program that will cover at least some prescription costs for elderly and disabled patients. You and your staff will want to know the basics of the new coverage, but you'll also need to be aware of the ways that this 600-page law will affect physicians.

President George W. Bush signed the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 in December of that year, stating that the new prescription drug benefit would help control drug prices by stimulating competition among the participating private companies. The act has sparked a controversy that resulted in the resignation of the chief administrator of the

Centers for Medicare & Medicaid Services (CMS) (see "Ex-Medicare Chief Deceived Congress About MMA Cost, GAO says," page 6).

The goal of the legislation is to give Medicare patients a voluntary drug benefit that will increase adherence with drug regimens and improve clinical outcomes. While critics say the plan is too complicated and limited, the law was supported by the American Medical Association, which called it "historic legislation for America's seniors and physicians." The law also halted proposed Medicare physician pay cuts and replaced them with a payment increase of not less than 1.5% over the next 2 years. A number of consumer groups, including the American Association of Retired Persons, also supported passage of the law. Drug manufacturers lobbied intensely for the legislation, which does not allow Medicare to negotiate with drug makers for discounts, as, for example, the Veterans Administration is allowed to do.

The long-awaited drug benefit

The most important, and expensive, section of the law provides for the Medicare-Approved Drug Discount Card Program, also known as Medicare Part D. Today, one quarter of the 40 million elderly and disabled individuals covered by Medicare have no drug coverage, and millions more

face rising drug coverage costs for Medigap and other programs. Beginning in 2006, the MMA will provide outpatient drug coverage to all Medicare beneficiaries (see "The Drug Benefit at a Glance," page 7). In the interim, a transition phase that began in May 2004—called the Transitional Assistance Program—provides some drug coverage.

Medicare develops contracts with private prescription drug plans (PDPs) to offer the intermediary program and will continue to do so when the new drug plan is implemented in 2006. Each company will set its own prices for drugs and develop and maintain its own drug formulary. By law, the formulary decisions must be based on standards of practice and scientific evidence, and sponsors will be required to provide notice to physicians and patients before removing drugs from a formulary. The new law also requires an appeals process for coverage of nonformulary drugs.

Beneficiaries must decide on a PDP in their service area and then find a pharmacy that participates in that plan. Or, they can use a mail order service if that option is also available. They must then remain enrolled with the company they choose until the end of the calendar year unless the patient moves to a service area where the selected PDP is unavailable; enters

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A Gloomy Forecast for the Medicare Program

On April 9, 2003, months before the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) was signed into law, David M. Walker, Comptroller General of the United States, shared the US General Accountability Office's (GAO's) budget-based anxieties with the Committee on Ways and Means, House of Representatives. While prescription drug coverage could surely be a lifeline for senior citizens struggling with medication costs, it is also clear that Medicare requires painstaking reform so that it does not collapse under rapidly increasing debt. Walker told listeners that before the MMA, the Medicare program had already begun moving toward financial calamity. "Medicare in its present form is not sustainable," he predicted. In the next 10 years alone, the drug benefit is likely to burn through hundreds of billions of dollars. Consider several other points that Walker made:

- In 2003, the actuarial deficit carried by the program's Hospital Insurance (HI) arm swelled by 20% to \$6.2 trillion. In 2013, HI costs will start to outpace the tax revenues supporting the Medicare program. Without significant intervention, the US government is destined to raise money from other sources to cover health care. "To obtain budget balance, it appears that massive spending cuts, tax increases, or some combination of the two would be necessary," he emphasized.
- The number of people aged 65 years and older will double by 2035.
- Premiums for Supplemental Medical Insurance cover roughly 25% of related benefits, with current workers paying the huge balance with their taxes. While "there were 4.9 working-age persons (18 to 64 years) per elderly person" to help foot the bill in 2002, the ratio is predicted to be 2.8 to 1 by 2030.
- The Congressional Budget Office predicted that in 2003, the average Medicare beneficiary would use \$2,440 worth of prescription drugs; an estimate made for 2005 is that approximately 12% of beneficiaries will require more than \$6,000 worth of prescription medications.

Walker's full testimony, entitled *Medicare: Observations on Program Sustainability and Strategies to Control Spending on Any Proposed Drug Benefit*, can be found on the Office of the Inspector General's (OIG) Web site at: www.gao.gov/cgi-bin/getrpt?GAO-03-650T. We delve into the anxiously awaited drug benefit in this month's cover article. As you will learn, there is an extra layer of controversy surrounding its formation, and it will be interesting to see how the legislation unfolds over the coming months. We also examine the 2005 Work Plan, which was recently unveiled by the OIG for the US Department of Health and Human Services. The document offers you some advance notice of the issues that government officials will be examining more closely in the very near future.



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OIG Investigates Numerous Aspects of Medical Practice

As 2004 winds down and assorted pundits start to share their predictions for the new year, set aside a couple of hours to read through the Fiscal Year (FY) 2005 Work Plan for the Office of the Inspector General (OIG) of the US Department of Health and Human Services. Published every October, the OIG's Work Plan is more useful to physicians than the most educated of speculations since it spells out each analysis that the government agency intends to launch, continue, or finish in the ensuing 12-month period.

The most pertinent section, entitled Medicare Physicians and Other Health Professionals, is in the chapter devoted to the Centers for Medicare and Medicaid Services (CMS). Fifteen studies of practitioners are on the schedule in FY 2005 versus 12 each in FY 2004 and FY 2003 and 10 in FY 2002. A perennial favorite since the 2002 Work Plan is coding of evaluation and management (E&M) services. Having previously discovered that substantial overpayments were made as a result of improper coding, the OIG will take a fresh look at the way physicians are handling these claims and whether mechanisms designed to ferret out "aberrant coding patterns" are sufficient.

"Coding of E&M services is always a problem," remarks Charles E. Colitre, president of Med-Management Group, Inc., based in Akron, Ohio. "CMS spends more money on total billing for these than other types of services. As a result, the OIG is always looking at it." Small errors can pile up until they represent large amounts of money. While profiling a practice's E&M billings is a fairly straightforward business, few physicians do so, he observes, adding, "It's pretty easy to spot a practitioner whose bills are not in line with those of other physicians in a group—or the whole practice may be out of whack

with national averages."

Modifiers are the targets of two ongoing studies. The OIG expects to finish up its investigation of practitioners' use of modifier "-25," which should only be employed when a physician provides a significant, unrelated E&M service to a patient who has had a procedure or has received another service on the same day. "A lot of money is involved, so that drives the government's interest in the issue," Colitre says. In fact, the OIG points to the \$1.7 billion spent on E&M services billed with modifier "-25" in 2001; \$23 billion was spent on all E&M services in that same year.

Also anticipated are the results of a study involving the National Correct Coding Initiative (NCCI) edits, which were developed to block payments for claims incorporating codes that are not typically billed together for the same person on the same date and those that are mutually exclusive. A number of modifiers, though, can be used to circumvent the edits when exceptions crop up, and the OIG is examining whether these are applied appropriately. Medicare Part B carriers receive updated NCCI files on a quarterly basis. The latest batch goes into effect on January 1, 2005, and you can view all of the NCCI files at: www.cms.hhs.gov/physicians/ccredits/.

Getting technical

Medicare Part A and Part B claims for overlapping services rendered to patients at skilled nursing facilities (SNFs) will be inspected to establish whether physicians or SNFs were paid twice for the same care. "Physicians may bill Medicare only for the professional component of a service on behalf of SNF patients," notes the OIG. "The technical component of physicians' services is covered under the patient's Medicare Part B stay in the SNF and should not be billed separately by the nursing home." However, the SNF and the physician can forge an agreement under which only the SNF bills Medicare Part B, subsequently obtaining the payment for both components.

The OIG will also examine Medicare payments for cardiography and echocardiography services to learn whether the professional and technical components of physicians' services were billed correctly. The professional portion corresponds to the physician's interpretation of results plus the costs inherent in doing that work—think overhead and professional liability insurance—while the technical element represents the cost of performing the test, which figures in expenditures for equipment, associated supplies, and technicians' salaries. When physicians

(Continued on page 4)

provide both components, the bill should include the appropriate CPT code without any modifier. In contrast, physicians providing only the interpretation would use the same CPT code and attach modifier “-26” to indicate that they are only to be paid for the professional component; the supplier of the tests’ technical component would affix modifier “-TC” to the CPT code.

The OIG is also reviewing office-based pathology services, which cost Medicare more than \$1 billion each year. The agency expects to learn more about relationships between physicians who provide pathology services within their practices and outside pathology firms.

Supervising care

A continuing project is targeting care plan oversight (CPO) claims from physicians who watch over the complicated or multidisciplinary treatment of beneficiaries in home health care or hospice programs. The question is whether physicians’ services are in line with Medicare regulations for CPO—a question spurred by a remarkable increase in Medicare payments for supervision of care. Medicare paid out \$15 million for CPOs in 2000 and \$41 million in 2001. “It’s an area where you could be accused of doing less than you billed for if you don’t document well,” Colitre warns.

In an October 2003 report, *Review of Medicare Care Plan Oversight in Puerto Rico (A-02-02-01019)*, the OIG discovered that “in all 30 claims tested, physicians did not maintain required supporting documentation in their medical records to establish that reimbursable CPO services had actually been provided and that their billings to Medicare were proper and justified.” The agency’s findings raised suspicions that more than \$2 million worth of claims were improperly reimbursed over a two-year period.

Physicians billing for CPOs must fulfill 12 requirements in order to be paid. For example, only the physician who has signed the home health agency (HHA) or hospice plan of care can submit CPO claims. In addition, at least 30 minutes of CPO services must be provided within the calendar month for which the bill is submitted, and the doctor sending in the claim must furnish these services.

More new areas of interest

In FY 2005, the OIG is looking into problematic dealings between billing companies and the Medicare providers who use them. The agency wants to determine whether arrangements between physicians and billing services have any influence on the claims sent in on practitioners’ behalf. Another project on the docket is an appraisal of Medicare payments made to physicians who are paid by the US Department of Veterans Affairs (VA) for time spent on duty at a VA hospital. These doctors cannot bill Medicare for care provided at other hospitals during periods they were on duty at a VA hospital.

Claims for physical and occupational therapy will be examined to ensure that they were “reasonable and medically necessary, adequately documented, and certified by physician certification statements,” the agency indicates. The medical necessity and billing of Part B mental health services rendered in physicians’ offices is also under scrutiny, as is the medical necessity of wound care services.

Long-distance claims—where the treating physician’s practice is a considerable distance from the patient’s home—have been studied in the past, but the OIG is embarking on a new investigation. It will also delve into distinctions in ownership between practices billing as provider-based (hospital-owned) and freestanding

entities. Because reimbursement differentials exist between the two, Medicare suspects it could be paying “excessive amounts” to practices billing under the wrong designation.

“Two things happen in my experience,” Colitre says. “Freestanding practices or clinics are purchased by hospitals, and nobody tells the physicians or the billing staff that the place of service has to be changed to a provider-based clinic.” Or, physicians may work in two practices—one freestanding and one provider-owned—and inadvertently bill services as if both were provided in freestanding locations. “I’ve seen it several times, so I don’t think it’s an isolated issue, and obviously, the OIG doesn’t either,” he continues.

Finally, the OIG is trying to determine how often Medicare pays for services provided by physicians who are excluded from the program. “Most hospitals with compliance programs perform annual checks on all of their physicians to make sure that they haven’t been excluded from the program,” Colitre says. “A small practice may never check them.” Any new hire’s credentials should be thoroughly checked. The OIG maintains a searchable Web site of excluded health care practitioners at: www.exclusions.oig.hhs.gov/search.html. You can also access a complete copy of the Work Plan at: www.oig.hhs.gov/publications/workplan.html. “Read through the index of the CMS chapter because you might find other pertinent areas,” Colitre concludes. “I always recommend that physicians study the hospital section. Those that work with HHAs or nursing homes should review the relevant portions. All essential information won’t necessarily be contained in one place.”

Reported and written by Cynthia Starr, editor. For more information on the issues described here, visit our Web site (see page 8).

Are Nursing Home Patients Eligible for the Drug Discount Card?

Q: Can a nursing home resident who is enrolled in Medicare Part B get a Medicare discount drug card.

A: Patients who are not already obtaining outpatient prescription drug benefits from Medicaid are candidates for a Medicare-approved drug discount card if they qualify for Medicare Part A or are enrolled in Medicare Part B. "The fact that this patient resides in a nursing home should not affect her eligibility, unless her stay is covered by Medicaid," says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Peak Performance Physicians, LLC, which is based in New Orleans. "If her income is below a certain level, she may also meet the criteria for the \$600 credit provided to low-income patients in 2004 and 2005." Eligible patients who use the same card in 2004 and 2005 can apply leftover credit from this year to next year's drug costs—along with another \$600 of credit automatically supplied in 2005. Patients need not fill out the paperwork again. In general, patients who qualify for the credit must:

- Have an annual gross income of \$12,569 or less if single; \$16,862 or less if married. Alaska and Hawaii have higher thresholds. Patients who receive state aid in paying

Medicare premiums can be considered for the credit even if their incomes are above the state limit. Expect the income ceiling to change next year.

- Be a resident of a US state or Washington, DC.
- Not be receiving outpatient prescription drug coverage through Medicaid, military health insurance, the Federal Employee Health Benefit Plan, an employer group health plan, or certain Medicare managed care plans.

Nursing home patients who meet all criteria and who are obtaining medication through the nursing home pharmacy should apply for one of three drug discount cards reserved for them (see table); the same is true for patients who already have a drug discount card when they move into a long-term care facility. It is important to know which company supplies a card through the nursing home pharmacy. Patients can't use the credit while Medicare Part A is shouldering their nursing home expenses.

Q: How should allergies be documented when I'm gathering information during a general examination?

A: "When I perform a chart audit, I place allergies with review-of-systems information or

past medical history," Picou says. "Of course, if you are talking about family members' allergies rather than the patient's, that would be documented with family history." The 1995 version of the *Documentation Guidelines for Evaluation and Management Services*, which are produced by the Centers for Medicare and Medicaid Services, defines past history as "the patient's past experiences with illnesses, operations, injuries, and treatments." Family history encompasses information about medical events in the family, such as those that are hereditary or otherwise increase a patient's risk of illness, and social history is described as an "age-appropriate review of past and current activities."

Q: If psychiatric counseling is provided to a patient who has a support person present during the session, should the billing include a code for individual therapy or group therapy?

A: "A patient and a support person do not constitute group therapy," Picou advises. Several patients would have to be treated together in order to meet the definition for group therapy. "If the support person is a spouse or family member, family psychotherapy codes might be an option," she adds. For example, if the support person is part of the treatment process and the relationship between the two is the focal point of the session, it would be appropriate to use 90847, the code for family psychotherapy (conjoint psychotherapy) (with the patient present).

Editor's note: Visit *The Physician's Compliance Alert Web site* (see page 8) and submit your questions. Members of our Advisory Board will offer their expert opinions.

Discount Cards for Medicare Patients in Nursing Homes

Card name	Sponsor	Telephone number
ACS State Healthcare	LLC and the Long-Term Care Pharmacy Alliance	1-866-490-1863
Community Care Rx	Computer Sciences Corp.	1-877-646-5307
PBM Plus Senior Care	PBM Plus, Inc.	1-800-676-8399

Source: Centers for Medicare and Medicaid Services

Ex-Medicare Chief Deceived Congress About MMA Cost, GAO Says

The Medicare Modernization Act (MMA) was passed in 2003, but it continues to stir up storms of controversy. Nearly a year after the law was passed, the US Government Accountability Office (GAO) charged that Thomas Scully, the former chief administrator for the Centers for Medicare & Medicaid Services (CMS), misled Congress on how much the new act would cost. The investigators even called for Scully to repay seven months of his government salary because he hid the higher estimates from Congress last year. The MMA, which gives Medicare beneficiaries a drug benefit, will cost about \$150 billion more than the \$400 billion the Bush administration claimed it would cost over the first 10 years, the GAO says.

The US Department of Health and Human Services confirmed that Scully threatened to fire chief Medicare actuary Richard Foster in 2003 to prevent him from giving precise cost information to lawmakers. Scully resigned in December of that year and is now employed at a private law firm. At CMS, Scully was paid a salary of \$145,600 a year. When asked if he would return part of his salary, he stated that "it's not up to the GAO." The federal law prohibits a federal agency from paying the salary of a government worker if he or she prevents another government official from communicating with Congress.

The release of the GAO report came about a week after an unprecedented rise of \$11.60 per month in the Medicare premium for nonhospital care. The administration has denied that any laws were broken and refuses to release about 150 pages directly related to the Foster estimates, despite requests by Democrats and the press. Foster is still working for CMS.

or leaves a long-term care facility; or enrolls in the Medicare Advantage program. The companies may charge an annual enrollment fee, but this cannot exceed \$35 and may be paid by Medicare for some low-income beneficiaries.

In 2006, beneficiaries will begin to receive Medicare-approved cards that will entitle them to a copayment system based on their income. Under the program, low-income beneficiaries will end up paying about 3% of the cost of their drugs, with Medicare covering the remaining amount. Low-middle-income beneficiaries will pay about 15%, and the beneficiaries with average incomes will pay about 47%. According to CMS, about one

third of all Medicare recipients will be eligible for low-income assistance.

Beneficiaries will have a \$250 yearly deductible, after which the benefit will pay an average of 75% of drug costs, up to a limit of \$2,250. Once the beneficiary pays \$3,600 out of pocket, about 95% of drug costs will be covered. There is no coverage for costs between \$2,250 and \$3,600 and no plan maximum.

Costs will be reduced even further for beneficiaries because PDPs will compete with each other and be able to negotiate prices with drug manufacturers, according to the US government. Additionally, PDPs will be required to maintain cost-management programs. The plans must also

encourage the use of generic drugs by offering cost incentives.

Beneficiaries with retiree coverage will also receive a drug subsidy, and employers and unions will be able to offer plans that "wrap around" the Medicare-subsidized drug coverage or offer the Medicare drug coverage themselves.

The new drug benefit also affects Medigap policies, which are currently offered by private companies to cover costs that are not paid by Medicare. New Medigap policies with a drug benefit will not be issued after December 31, 2005. For those who already pay for a Medigap policy that covers Medicare Part A and B, with or without a drug benefit, existing policies will continue as they are. Beneficiaries can keep the drug coverage they may have with Medigap or receive their drug coverage under the drug discount card program.

Both the card program and the transitional program are available to all beneficiaries eligible for or enrolled in Medicare Part A or enrolled in Medicare Part B, unless they receive drug coverage through state Medicaid programs. For dual-eligible beneficiaries who are also in low-income programs, each state can devise a way for its plans to supplement the new drug benefit.

The transitional program is in effect for only another year, but it's worth understanding what is provided. Beneficiaries can enroll early in Medicare-approved private programs for specified drug discounts. To date, about 4 million have signed on. There will be no financial subsidy from the US government until 2006, however, when Medicare drug benefit cards are issued. A credit of \$600 is included to go toward the cost of drugs in 2004 and 2005. Only low-income beneficiaries without other drug coverage are eligible for the credit.

The Drug Benefit at a Glance

Here, at a glance, is what the new Medicare drug benefit will offer beneficiaries as of 2006:

- The law allows all Medicare beneficiaries to voluntarily enroll in a Medicare-approved drug plan or a Medicare health plan.
- The plans will pay an average of 75% of the cost of drugs after a \$250 deductible is met, up to an initial coverage limit of \$2,250. The actual percentage will vary based on beneficiary income.
- The plans will not cover drug costs between \$2,250 and \$3,600.
- The plans will pay about 95% of prescription costs after the beneficiary has paid \$3,600 per year out of pocket.

Changes to reimbursement

The MMA directly affects physicians as well, particularly in terms of Medicare reimbursement. One important change states that if physicians are required to repay "overpayments" after an audit, they will not be required to pay until after their appeal has been heard. In addition, the payments can be made in installments rather than in the current 30 to 60 days. Also, limits will be placed on the use of "extrapolations," which multiply errors made on a few claims to calculate enormous overpayment demands.

Other changes include:

- An average across-the-board 1.5% increase in payment rates for physicians in 2004 and 2005.
- The halting of a projected 3.7% decrease for 2005 that would have been allowed under the old law.
- Added pay incentives for doctors practicing in underserved areas.
- New coverage for a one-time patient evaluation by hospice doctors.
- Payment rates for respiratory drugs will now be based on average sales price rather than the current 80% of the average wholesale price.
- Metered dose inhalers will be covered in addition to nebulized medications.
- In 2005 and 2006, oncologists'

reimbursement for cancer drugs will be average sales price plus 6%.

- Elimination of the cross-subsidy in payments for drugs used to treat patients with end-stage renal disease (ESRD). Payments will reflect the acquisition costs of the drugs while increasing payment rates for providers. ESRD facilities will also earn higher rates for treating certain types of patients, such as those with AIDS or peripheral vascular disease. An overall 1.6% increase for all services provided will also be initiated.
- Reduced payments for drugs administered in doctors' offices. At the same time, increased payments for administration of the drugs will go into effect. The American Society of Clinical Oncology has lobbied to restore rates for drugs given in physicians' offices and claims the average reduction will be 15% rather than the 8% the administration claimed. (Medicare spent \$10.5 billion in 2003 on prescription medications administered in doctors' offices and clinics.)
- New coverage for all screening and stabilization services that are subject to the requirements of the Emergency Medical Treatment and Active Labor Act. Physicians must also be prepared

for the mandatory use of electronic prescriptions by the year 2009. These will be required for all prescriptions written for Medicare beneficiaries who enroll in the new plans for the Part D drug benefit. The MMA provides grants to help physicians invest in electronic prescribing systems.

Other benefit changes

A number of provisions other than the drug benefit will also directly affect Medicare beneficiaries. One significant change gives beneficiaries new access to preferred provider organizations, an option that will probably prove very popular. For one reason, increased payments to Medicare HMOs that began in 2004 have already led some states to reduce subscriber premiums and patient copayments and increase prescription drug coverage for their managed care Medicare plans.

Another important benefit included under the new law is a one-time wellness benefit, starting up in 2005, which will be offered to all new Medicare recipients. The benefit will cover a physical examination and screening tests for early detection of diabetes and cardiovascular disease.

Lawmakers hope that these vast changes to Medicare will help meet the prescription coverage needs of beneficiaries. Patients and physicians will soon learn whether the new law fulfills its promise.

Note: The 24-hour/7-day Medicare hotline number is 800-633-4227. Medicare beneficiaries can call the hotline for price comparisons for different drug discount cards and for information on the new drug benefit. Eligibility, enrollment, and price comparison information can also be found at www.medicare.gov/AssistancePrograms/home.asp.

Reported and written by Deborah Epstein, contributing editor, in West Milford, NJ. More information on Medicare coverage is on our Web site (see page 8).

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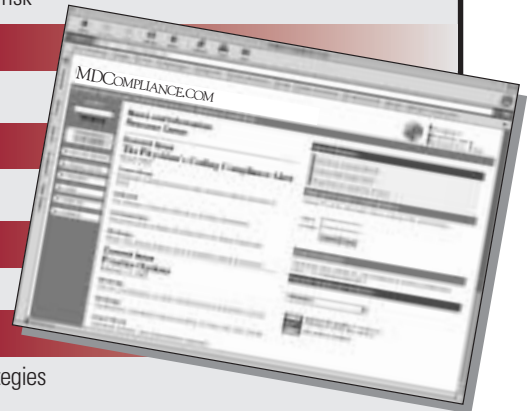
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