

# IMS Advocate

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## **Key legislation post-funnel**

**SSB 3085/HF 2136** – Define the practice of chronic interventional pain medicine and who may practice it. IMS supports. Died in funnel.

**HF 2075** – Requires health benefit coverage for certain cancer treatments pursuant to approved cancer clinical trials. IMS supports. Bill passed and sent to Governor.

**HF 2297** – Licenses direct entry lay midwives. IMS opposes. Still viable.

**HJR 2006/SJR 2003** – Nullify an Iowa Board of Nursing rule allowing ARNP supervision of fluoroscopy. IMS supports. Died in funnel.

**HF 234** – Requires insurance coverage for mental health conditions, including substance abuse treatment. IMS supports. Still viable.

**HF 2329** – Provides payment for medication therapy management. IMS is monitoring. Still viable.

**SF 153** – Allows PAs to form a professional corporation. IMS opposes. Passed Senate; still viable.

**SF 2005** – Creates noneconomic damages cap in med mal actions. IMS supports. Died in funnel.

**SF 2150** – Establishes teen graduated driver licensing program. IMS supports. Passed Senate; still viable.

**SF 2333** – Relates to hospital inspectors and dependent adult abuse. IMS is monitoring. Still viable.

**SF 2312** – Licenses naturopathic physicians. IMS opposes. Still viable.

**SF 2072** – Establishes involuntary hospitalization protocol. IMS is monitoring. Still viable.

## **Legislature releases budget targets**

Legislative leaders released state fiscal year 2011 budget targets this week. The Health and Human Services Appropriations Subcommittee target is \$172 million less than the state fiscal year 2010 budget. This legislative proposal appears to rely on Congress acting to provide states additional federal stimulus money and an increased Medicaid match to balance the budget. Unfortunately, there is no indication that Congress will act soon or have such a legislative vehicle. If the legislative targets hold, Medicaid will face substantial cuts. Only three ways exist to cut Medicaid spending: 1) decrease the number of groups eligible for Medicaid; 2) reduce the number of services available under Medicaid; or 3) cut provider reimbursement rates.

Iowa Medicaid providers already took a five percent cut when the Governor reduced all of state government spending by ten percent in October 2009. No details on the Health and Human Services budget are yet available. The first closed door session of the Appropriations Subcommittee was held on February 18. Additionally, the legislators will wait until the state's Revenue Estimating Conference meeting on March 11 before finalizing any of the budgets. The legislature is scheduled to adjourn March 31.

## **Contact your Senators today re: Medicare payment reform**

A proposal is being circulated in the U.S. Senate to delay a looming 21 percent cut in Medicare physician payments scheduled to take effect March 1. IMS urges physicians to call their senators and insist that they pass legislation to repeal Medicare's sustainable growth rate (SGR) formula once and for all. It is time for Congress to address the SGR problem head-on and permanently fix the problem. Visit [www.iowamedical.org](http://www.iowamedical.org) to learn more and to access contact information for Senators Grassley and Harkin.

## **Rule establishes mental health parity requirements**

An interim final rule was released in the February 2 *Federal Register* by three federal agencies (Treasury, Labor, and CMS) to implement the "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008" (MHPAEA). This law requires health plans to treat benefits for mental health and substance abuse coverage in the same way as medical and surgical benefits for employer groups of more than 50 employees. The new law and its regulations are designed to address national evidence showing many covered workers have higher cost-sharing imposed on mental health care benefits and greater restrictions in areas such as covered hospital days, mental health visits, and rehabilitation.

The three agencies expect that the greatest benefits of the MHPAEA will be derived from applying parity to cumulative treatment limitations such as annual or lifetime day or visit limits. There are many complexities in this rule, including identification of those health plans to which the rule applies. Its provisions are effective for health plan years beginning on or after July 1, 2010.



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## IMS HOD news: Resolutions due April 9; Robert's Rules to be used

The Speaker and Vice-speaker of the IMS House of Delegates (HOD) have decided to institute a deadline prior to the HOD meeting for all member resolutions. Resolutions should now be sent to IMS by Friday, April 9, in advance of the IMS Annual Meeting April 16-18.

Resolutions submitted after April 9 will still be reviewed. If the issue is not urgent, it will be forwarded to the IMS Board of Directors for discussion at their May meeting. In past years, resolutions were taken up until the HOD meeting. This allowed for no background research and consequently limited debate. This change should ensure more information is provided to the HOD in advance of discussion. If members have questions about introducing resolutions, please contact Ed Whitver at [ewhitver@iowamedical.org](mailto:ewhitver@iowamedical.org) or (515) 223-1401.

Additionally, the HOD is changing its parliamentary rules. The *Davis Rules of Order* is now out of print. As a result, the HOD will be following *Robert's Rules of Order*. Delegates can attend the April 17 HOD orientation session to hear an overview of the new procedures.

## 2008 Medicare and Medicaid E/M utilization data available

IMS has prepared an Excel report that compares 2008 evaluation and management (E/M) data for Iowa Medicare, national Medicare, and Iowa Medicaid. The expected use of any E/M code range is a bell curve. If physicians are billing outside the expected use of E/M codes, there is a risk of audit. Find the report under the "Medicare" tab at [www.iowamedical.org](http://www.iowamedical.org).

## CMS identifies claims crossover problems

CMS identified a problem where Medicare claims were not automatically crossing over to supplemental payers even though the provider remittance advice indicated otherwise. This problem began January 5, 2010. Action is required on behalf of Part B professional providers where a remittance advice with an issue date between January 5, 2010, and February 12, 2010, has two or more service lines for a beneficiary where both of the following apply:

1. One service line is 100 percent reimbursable (i.e., the approved amount and amount to be paid are equal); **AND**
2. One service line where part of or the entire Medicare approved amount is applied to the Part B deductible and/or carries co-insurance amounts.

CMS is not able to forward these beneficiary claims. Providers will need to identify these claims and balance bill the beneficiary's supplemental payer. As of February 12, 2010, this problem was fixed and all claims are crossing over to supplemental payers as indicated on the provider remittance advice. CMS has already notified supplemental payers of these issues.

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