IMS Advocate
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Iowa Legislature active on health issues

The Iowa Legislature is considering many health-related pieces of legislation this session. This week, the Senate Ways and Means Committee passed the increased tobacco tax out of committee. The bill, ***SF 128***, was modified to create a health care-directed trust fund for tobacco tax proceeds. The bill now moves to the full Senate. Additionally, ***SF 34*** passed the Senate. This bill, which now moves to the House, requires a child restraint system or seat belt for all motor vehicle passengers under 18 years of age.

The Health and Human Services Appropriations Subcommittee finished discussions on the "Comprehensive and Affordable Health Care to Families and Small Business Act," which will move to the Senate Appropriations Committee. It contains many provisions, including the expansion of Medicaid to cover parents up to 50% of the federal poverty level. Many of the health care coverage expansions outlined in the bill would be financed by the $1 per-pack increase in the cigarette excise tax provided in ***SF 128***.

Medicare to require some providers to use 9-digit ZIP codes

Effective for dates of service on or after October 1, 2007, the use of 9-digit ZIP codes will be required by some providers who submit claims for payment under the Medicare Physician Fee Schedule or for anesthesia services. The Centers for Medicare & Medicaid Services (CMS) is implementing this requirement to prevent payment issues generated by ZIP codes that cross payment localities. If services are rendered in one of the designated ZIP code areas and a 9-digit ZIP code is not provided, claims will be treated as unprocessable. If a valid 9-digit ZIP code is not on the Provider Master File Address, providers will need to submit one via a CMS-855A Medicare Enrollment Application. Currently, Iowa only has six ZIP code areas that cross payment localities: 51630, 51640, 52542, 52573, 52626, 52761. For more information on this new requirement, view MLN Matters article MM5208, which may be found at **www.cms.hhs.gov/MLNMattersArticles**.

Rural Medicare equity bill introduced in Congress

On February 7, Sen. Russell Feingold (D-WI) introduced ***S 498***, the "Rural Medicare Equity Act of 2007." The bill addresses the payment inequities that exist in the Medicare program in the hopes that improved physician reimbursement will improve access and quality for rural Medicare beneficiaries. The bill contains five provisions, including fairer reimbursement for rural physicians through the elimination of the geographic practice cost index (GPCI) for work. Additionally, the bill would require the U.S. Secretary of Health and Human Services to examine data reform for the practice expense GPCI. The bill would also provide for demonstration projects in rural health and an adjustment of the Medicare Payment Advisory Committee (MedPAC) membership to better represent rural interests. IMS is writing a letter in support of the bill and encourages all members of the Geographic Equity in Medicare (GEM) Coalition to do the same.

Key legislation

SSB 1094 – Requires Certificate of Merit filing before a medical malpractice claim. IMS supports.

SF 128 (Successor to ***SSB 1055***) – Increases the excise tax on cigarettes by $1 a pack. IMS supports.

HSB 89/SSB 1162 – Allows local governments to adopt smoking bans. IMS supports.

SF 49 – Provides a .08 blood alcohol limit for motorboat or sailboat operating. IMS supports.

SF 43 – Authorizes school districts and nonpublic schools to provide comprehensive sexual health education. IMS supports.

SF 61 – Establishes state and school anti-harassment and anti-bullying policies. IMS supports.

HSB 94/SSB 1097 – Relates to access during litigation to communications concerning health care and health care records. IMS opposes.

HSB 72 – Limits the fees health care providers can charge for copies of medical records in connection with certain civil actions. IMS opposes.

HSB 71/SSB 1099 – Provides that debtors' personal injury structured settlements are exempt from creditors in legal actions. IMS opposes.

HSB 121/SSB 1138 – Relates to a parent's cause of action for the recovery of expense and loss related to injury or death of a child. IMS opposes.

HSB 122/SSB 1145 – Relates to statute of limitations in medical malpractice cases. IMS opposes.

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IOWA MEDICAL SOCIETY

This newsletter is a benefit of your membership in the Iowa Medical Society. Thank you for your support of our advocacy efforts in the Iowa Legislature, the regulatory arena, the private sector and in Congress.

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Medicare amends COPs for hospitals

Medicare-participating hospitals must adhere to federal Medicare conditions of participation (COPs). The COP rules have been amended in two areas of interest to Iowa physicians.

Verbal orders. For a five-year period beginning January 26, 2007, all orders, including verbal orders, must be dated, timed and authenticated promptly by the ordering practitioner or another practitioner responsible for the care of the patient and authorized by hospital policy to write orders consistent with state law. All verbal orders must be authenticated within 48 hours unless state law provides otherwise. Iowa Code section 135B.7A directs the Department of Inspections and Appeals (DIA) to adopt rules for authentication of medication and standing orders by practitioners within a period not to exceed 30 days following a patient's discharge. Conforming DIA rules (Iowa Administrative Code 481-51.14(3) and (4)) state that medication orders must be in writing and signed by the prescribing practitioner within a period not to exceed 30 days following a patient's discharge. Standing orders, among other things, must be signed by the prescribing practitioner within a period not to exceed 30 days following a patient's discharge. Section 135B.7A and these implementing regulations expire effective June 30, 2007. If not renewed by the Iowa General Assembly, the 48-hour time frame for authentication of verbal orders set forth in Medicare's COPs will govern.

Postanesthesia evaluations. Medicare's COPs now state that postanesthesia evaluations must be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery. The comments to this amended rule state that while the practitioner who administers the anesthesia is most familiar with the patient, other practitioners qualified to administer anesthesia can safely perform postanesthesia evaluations and determine the patient's response to and recovery from anesthesia.

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