

# Welcome to the E-version of the LGT Physician's View Point Newsletter

HINT!



CLICK THE MORTAR AND PESTLE TO  
RETURN TO TABLE OF CONTENTS



**Lane Gorman Trubitt, PLLC**  
*Accountants & Advisors*

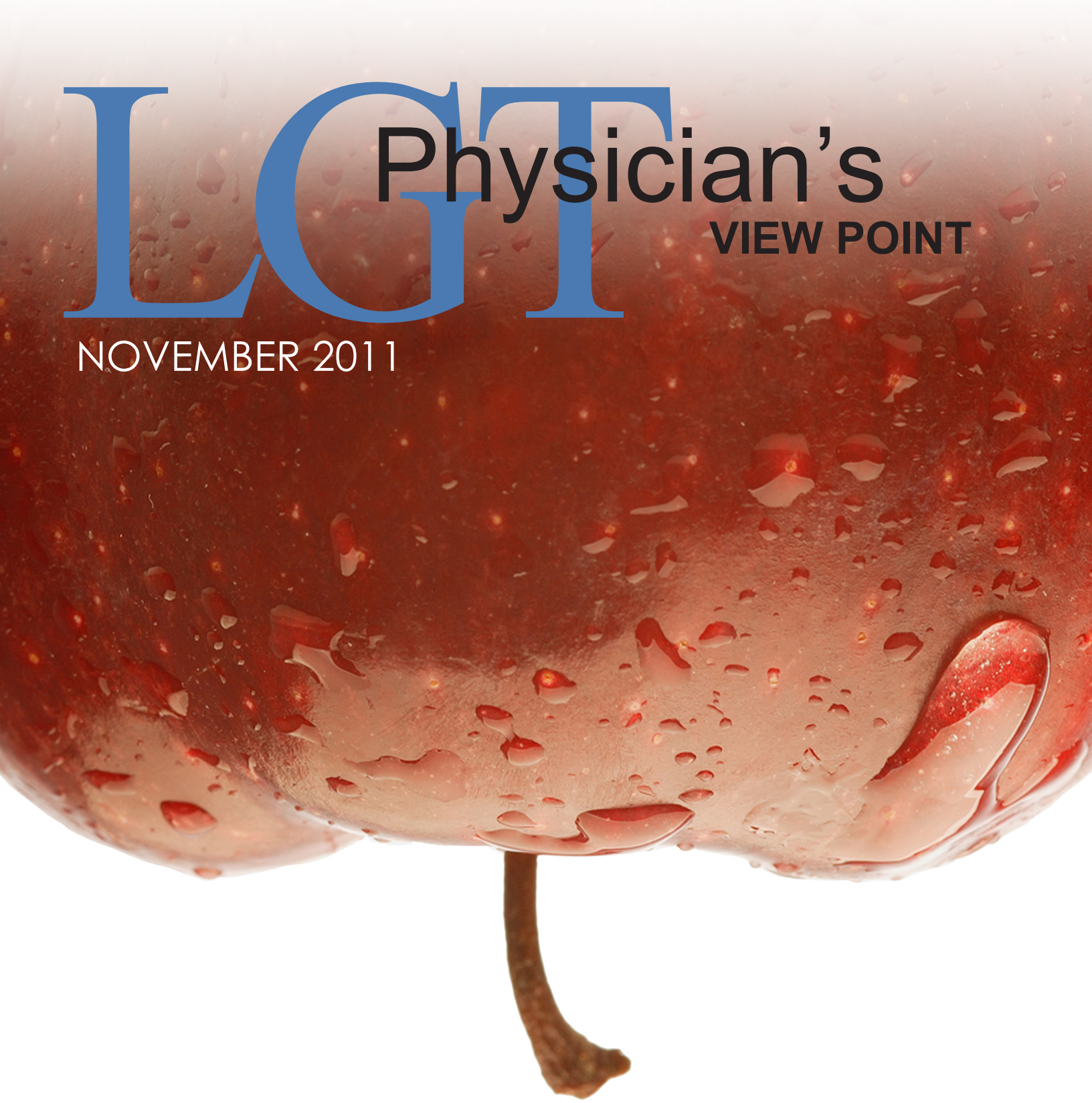
*The Power of the Right People Beside You™*

© 2011 Lane Gorman Trubitt, PLLC  
Accountants & Advisors  
[www.lgt-cpa.com](http://www.lgt-cpa.com)

2626 Howell Street Suite 700  
Dallas, TX / 75204

877.231.7500 TOLL FREE  
214.871.0011 FAX

LGT's e-brochure [www.lgt-cpa.com/e.asp](http://www.lgt-cpa.com/e.asp)



# IGT

Physician's  
VIEW POINT

NOVEMBER 2011

Expanded Benefits

---

Preventive Immunizations

---

Accountable Care Organizations

---

NOVEMBER 2011

*Physician's View Point – Brought to you by  
Lane Gorman Trubitt, PLLC*

[www.lgt-cpa.com](http://www.lgt-cpa.com)

---

## LGT HEALTHCARE SERVICES INCLUDE

Accounts Receivable Collections  
Buy/Sell Agreements  
Compliance Services  
Design Of Corporate Structure  
Employment Search  
ERISA 404(C) Compliance  
Evaluation & Management Coding  
HIPAA Consulting  
Insurance Consulting/Analysis

---

## PRIMARY CONTACT

Now head of our firm's ACS Department and Healthcare Group, Robert Lane has been in practice for over 30 years. He is certified as a Personal Financial Specialist (PFS) by the American Institute of Public Accountants (AICPA) and holds a state of Texas CPA license. In addition, he holds both Texas and federal securities licenses.

For more information about LGT or to speak to a Healthcare Specialist please contact Robert Lane, Partner at 214-461-1450.



e-mail Robert...  
[rlane@lgt-cpa.com](mailto:rlane@lgt-cpa.com)

## INSIDE FEATURES

---

Expanded Benefits

Preventive Immunizations

Accountable Care Organizations



# Expanded Benefits

## THE INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE)

The Affordable Care Act allows Medicare to cover a one-time IPPE. (This is also referred to as the “Welcome to Medicare” physical exam or the “Welcome to Medicare” visit.)

The IPPE is a preventive Evaluation and Management (E/M) service that includes seven components:

1. Review of the beneficiary’s medical and social history with attention to modifiable risk factors for disease detection.
2. Review of the beneficiary’s potential risk factors for depression or other mood disorders.
3. Review of the beneficiary’s functional ability and level of safety.
4. An examination to include measurement of the beneficiary’s height, weight, blood pressure; measurement of body mass index; a visual acuity screen; and other factors as deemed appropriate by the physician or qualified non-physician practitioner, based on the beneficiary’s medical and social history and current clinical standards.
5. End-of-life planning, upon the beneficiary’s consent.
6. Education, counseling, and referral based on the previous five components.
7. Education, counseling, and referral for other preventive services including a brief written plan, such as a checklist, provided to the beneficiary for obtaining a screening EKG, if appropriate, and the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits.

**NOTE: The IPPE does not include any clinical laboratory tests. The physician, qualified non-physician practitioner, or hospital may also provide and bill separately for the screening and other preventive services that are currently covered and paid for by Medicare Part B.**

### Coverage Information

Medicare provides coverage of the IPPE for all newly enrolled beneficiaries who receive the IPPE within the first 12 months after the effective date of their Medicare Part B coverage. The IPPE is covered only as a one-time benefit per Medicare Part B enrollee. Medicare beneficiaries who cancel their Medicare Part B coverage but later re-enroll in Medicare Part B are not eligible for the IPPE benefit.

The IPPE must be furnished by either a physician or a qualified non-physician practitioner.



**NOTE: This exam is a preventive visit and not a “routine physical checkup” that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare Part B does not provide coverage for routine physical exams.**

## PREPARING BENEFICIARIES FOR THE IPPE VISIT

Providers can help beneficiaries get ready for the IPPE visit by encouraging them to come prepared with the following information:

- Medical records, including immunization records;
- Family health history, in as much detail as possible; and
- A full list of medications and supplements including calcium and vitamins—how often and how much of each is taken.

Medicare provides coverage of the IPPE as a Medicare Part B benefit. For dates of service on or after January 1, 2009, the Medicare Part B deductible is waived for the IPPE. For dates of service on or after January 1, 2011, both the coinsurance or copayment and the Medicare Part B deductible are waived for the IPPE.



## ULTRASOUND SCREENING FOR ABDOMINAL AORTIC ANEURYSMS (AAA)

Medicare Part B covers a one-time only preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at risk beneficiaries. Eligible beneficiaries must receive a referral for this screening service as a result of their IPPE visit.

Ultrasound screening for AAA is a procedure that:

- Uses sound waves (or other procedures using alternative technologies, of commensurate accuracy and cost, as specified by the Centers for Medicare & Medicaid Services [CMS] through the national coverage determination process) provided for the early detection of AAA; and
- Includes a physician's interpretation of the results of the procedure.

### Coverage Information

Medicare provides coverage of a one-time preventive ultrasound screening for the early detection of an AAA for eligible beneficiaries who meet the following criteria:

- The beneficiary receives a referral for an ultrasound screening for AAA as a result of an IPPE;
- The beneficiary receives a referral from a provider or supplier who is authorized to provide covered ultrasound diagnostic services;
- The beneficiary has not been previously furnished an ultrasound screening for AAA under the Medicare Program; and
- The beneficiary is included in at least one of the following risk categories:
  - The beneficiary has a family history of AAAs;
  - The beneficiary is a man 65 through 75 years of age who has smoked at least 100 cigarettes in his lifetime; or
  - The beneficiary manifests other risk factors in a beneficiary category recommended for ultrasound screening by the United States Preventive Services Task Force (USPSTF) regarding AAAs, as specified by the Secretary of Health and Human Services through the national coverage determination process.

**NOTE: Only Medicare beneficiaries who receive a referral for the ultrasound screening for AAA as a result of the IPPE will be covered for this benefit.**

Medicare provides coverage of the ultrasound screening for AAA as a Medicare Part B benefit. The coinsurance or copayment applies to this benefit. The Medicare Part B deductible is waived. For dates of service on or after January 1, 2011, both the coinsurance and copayment and deductible are waived.

## CARDIOVASCULAR SCREENING BLOOD TESTS



Medicare provides coverage of cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke.

The cardiovascular screening blood tests covered by Medicare include the following:

- Total cholesterol test; n Cholesterol test for high-density lipoproteins; and
- Triglycerides test.

**NOTE: The beneficiary must fast for 12 hours prior to testing. Other cardiovascular screening blood tests remain non-covered.**

### Coverage Information

Medicare provides coverage of cardiovascular screening blood tests for all asymptomatic beneficiaries every 5 years (i.e., at least 59 months after the last covered screening tests).

The physician or qualified non-physician practitioner treating the beneficiary must order the cardiovascular screening blood test for the purpose of early detection of cardiovascular disease. The beneficiary must have no apparent signs or symptoms of cardiovascular disease.

### STAND ALONE BENEFIT:

The cardiovascular screening blood tests benefit covered by Medicare is a stand alone billable service separate from the IPPE and does not have to be obtained within a certain time frame following the beneficiary's Medicare Part B enrollment.

Medicare provides coverage of the cardiovascular screening blood tests as a Medicare Part B benefit. The beneficiary will pay nothing for the cardiovascular screening blood tests (there is no coinsurance or copayment and no Medicare Part B deductible for this benefit).



# Preventive Immunizations

## SEASONAL INFLUENZA

Influenza is a contagious disease caused by influenza viruses that generally occurs during the winter months. It attacks the respiratory tract in humans (nose, throat, and lungs).

The risks for complications, hospitalizations, and deaths from influenza are higher among individuals aged 65 and older, young children, and persons of any age with certain underlying health conditions than the risks for complications among healthy older children and younger adults. A seasonal influenza vaccination is still the best way to prevent influenza and its severe complications.

## SEASONAL INFLUENZA VACCINE

### Risk Factors for Influenza

Medicare provides coverage of the seasonal influenza virus vaccine and its administration for all Medicare beneficiaries regardless of risk for the disease; however, some individuals are at greater risk for contracting influenza. Vaccination is recommended for all individuals aged six months and older.

While everyone should get a seasonal influenza vaccine each influenza season, it's especially important that certain groups get vaccinated either because they are at high risk of having serious influenza-related complications or because they live with or care for people at high risk for developing influenza-related complications. For more information, refer to the most recent recommendations at <http://www.cdc.gov/flu/protect/keyfacts.htm> on the Centers for Disease Control (CDC) website.

### Who Should Not Get the Seasonal Influenza Vaccine

According to the CDC, individuals in the following groups should not be vaccinated without consulting a physician:

- Individuals with a severe allergy to chicken eggs,
- Individuals who have had a severe reaction to an influenza vaccination in the past,
- Individuals who previously had onset of Guillain-Barre syndrome during the 6 weeks after receiving the influenza vaccine,
- Children less than 6 months of age. and
- People who have a moderate or severe illness with a fever should wait until their symptoms lessen.

## COVERAGE INFORMATION FOR SEASONAL INFLUENZA

Medicare provides coverage of one seasonal influenza virus vaccine per influenza season for all beneficiaries. This may mean



that a beneficiary will receive more than one seasonal influenza vaccination in a 12-month period. Medicare may provide coverage for more than one seasonal influenza vaccination per influenza season if a physician determines, and documents in the beneficiary's medical record, that the additional vaccination is reasonable and medically necessary. Medicare provides coverage of the influenza vaccination as a Part B benefit. If the beneficiary receives the service from a Medicare-enrolled provider, the beneficiary will pay nothing.

## PNEUMOCOCCAL DISEASE

Pneumococcal disease is an infection caused by the bacteria *Streptococcus pneumoniae*, also known as pneumococcus. The most common types of infections caused by this bacterium include: middle ear infections, pneumonia, blood stream infections (bacteremia), sinus infections, and meningitis. Invasive pneumococcal infection kills thousands of people in the United States each year, most of them aged 65 and older. While influenza viruses generally strike during the winter months, pneumococcal disease occurs year-round.

## PNEUMOCOCCAL POLYSACCHARIDE VACCINE (PPV)

### Risk Factors for Pneumococcal Infection

The CDC identifies high priority target groups for the pneumococcal vaccination. For more information, refer to the most recent recommendations at <http://www.cdc.gov/vaccines/vpd-vac/pneumo/in-short-both.htm#who> on the CDC website.



### COVERAGE INFORMATION FOR PPV

Medicare generally provides coverage of pneumococcal vaccination once in a lifetime for all Medicare beneficiaries. Medicare may provide coverage of additional vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status.

### REVACCINATION

Pneumococcal vaccine is typically administered to adults once in a lifetime. However, revaccination may be appropriate for beneficiaries at highest risk for pneumococcal disease and those most likely to have rapid declines in antibody levels. This group includes individuals with the following conditions:

- Functional or anatomic asplenia e.g., sickle cell disease, splenectomy)
- Human Immunodeficiency Virus,
- Leukemia,
- Lymphoma,
- Hodgkin's disease,
- Multiple myeloma,
- Generalized malignancy,
- Chronic renal failure,
- Nephrotic syndrome, or
- Other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy.

**NOTE:** *If a beneficiary who is not at highest risk is revaccinated because of uncertainty about his or her pneumococcal vaccination status, Medicare will pay for the revaccination. Routine revaccinations of beneficiaries who are not at highest risk are not appropriate.*

Medicare provides coverage of the influenza vaccination as a Part B benefit. If the beneficiary receives the service from a Medicare-enrolled provider, the beneficiary will pay nothing.

### HEPATITIS B VIRUS (HBV)

Hepatitis B is a serious disease caused by the HBV. The virus can affect people of all ages. Hepatitis B attacks the liver and can cause chronic infection, resulting in cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. The virus is found in the blood and body fluids of infected people and can

be spread through sexual contact; the sharing of needles, other drug paraphernalia, and razors; tattoos or body piercing; from a mother to her infant during birth; and by living in a household with a chronically infected person.

### HBV VACCINE

#### Risk Factors for Hepatitis B Infection

Medicare provides coverage for certain beneficiaries at high or intermediate risk for HBV infection.

#### Vaccination is recommended for the following high risk groups:

- Individuals with End Stage Renal Disease (ESRD),
- Individuals with hemophilia who received Factor VIII or IX concentrates,
- Clients of institutions for the mentally handicapped,
- Persons who live in the same household as an HBV carrier,
- Homosexual men, and Illicit injectable drug users.

#### Vaccination is recommended for the following intermediate risk groups:

- Staff in institutions for the mentally handicapped, and
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

**Exception:** Persons in the above-listed groups would not be considered at high or intermediate risk if they have laboratory evidence positive for antibodies to HBV (ESRD patients are routinely tested for HBV antibodies as part of their continuing monitoring and therapy).

#### Coverage Information for HBV

Medicare provides payment for the HBV vaccine and its administration, for beneficiaries at intermediate to high risk of contracting HBV. Medicare requires that the HBV vaccine be administered under a physician's order with supervision. Medicare provides coverage for the hepatitis B vaccine as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.



# Accountable Care Organizations

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), proposed new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

Under the proposal, ACOs – teams of doctors, hospitals, and other health care providers working together – would coordinate and improve care for patients with Original Medicare – Medicare Parts A and B. ACOs would have to meet high quality standards to ensure patients are happy with the care they receive and have better health outcomes; and if ACOs can help save money by getting patients the right care at the right time, they can share in those savings with Medicare. As proposed, ACOs could also have to pay back Medicare for failing to provide efficient, cost-effective care. The new program would begin on January 1, 2012.

Under the proposed rule, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients they serve in Original Medicare. The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from different providers receiving different, disconnected payments. The ACO would be a patient-centered organization where the patient and providers are partners in care decisions.

The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint ventures arrangements between hospitals and ACO professionals,
- Hospitals employing ACO professionals, or
- Other Medicare providers and suppliers as determined by the Secretary.

In the proposed rule, the Secretary has made clear that certain critical access hospitals are eligible to participate in the Shared Savings Program.

To participate in the Shared Savings Program, providers must form or join an ACO and apply to CMS. An existing ACO will not be automatically accepted into the Shared Savings Program. If accepted, they would serve at least 5,000 Medicare patients and agree to participate in the program for three years. Medicare providers who join an ACO that participates in the program would continue to receive payment under Original Medicare Fee-For-Service (FFS) rules.

The statute also requires each ACO to establish a governing body representing ACO providers of services, suppliers, and Medicare beneficiaries. The ACO would be responsible for monitoring and reporting of the care it delivers. The proposed rule outlines a monitoring and reporting plan that includes analyzing claims and specific financial and quality data, producing quarterly and annual aggregated reports, performing site visits, and conducting beneficiary surveys.

Under the proposed rule, Medicare would continue to pay individual providers and suppliers for specific items and services as it currently does under the Original Medicare payment systems. CMS would also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or be held accountable for losses. The benchmark is an estimate of what the total Medicare FFS Parts A and B expenditures for ACO beneficiaries would otherwise have been in the absence of the ACO, even if all of those services would not have been provided by providers in the ACO. The benchmark would take into account beneficiary characteristics and other factors that may affect the need for health care services. This benchmark would be updated for each performance year within the three-year performance period.

CMS is proposing to implement both a one-sided risk model (sharing of savings only for the first two years and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years), allowing the ACO to opt for one or the other models. CMS believes this approach would have the advantage of providing an entry point for organizations with less experience with risk models, such as some physician-driven organizations or smaller ACOs, to gain experience with population management before transitioning to a risk-based model, while also providing an opportunity for more



## Accountable Care Organizations *(continued from page 5)*

---

experienced ACOs that are ready to share in losses to enter a sharing arrangement that provides a greater share of savings, but at the risk of repaying Medicare a portion of any losses.

CMS is also proposing to establish a minimum savings rate (MSR) that would account for normal variations in health care spending. The minimum savings rate is a percentage of the benchmark that ACO expenditure savings must exceed in order for an ACO to qualify for shared savings in any given year. Under the proposed rule, ACOs in the one-sided risk program that have smaller populations (and having more variation in expenditures) would have a larger MSR and ACOs with larger populations (and having less variation in expenditures) have a smaller MSR. Under the two-sided approach, CMS is proposing a flat 2 percent minimum savings rate.

If an ACO meets quality standards and achieves savings exceeding the minimum savings rate, the ACO would share in savings, based on the quality score of the ACO. The proposed rule would provide for additional shared savings for ACOs that include beneficiaries who receive services from a Federally Qualified Health Center or Rural Health Clinic during the performance year.

CMS is encouraging providers to participate in the Shared Savings Program in 2012 by setting the quality performance standard to reporting only. ACOs would be eligible for the maximum sharing rate (60 percent for the two-sided model and 50 percent for the one-sided model) if the ACO generates sufficient savings and successfully reports the required quality measures. This flexibility would allow newly formed ACOs a grace period as they start up their operations and learn to work together to better coordinate patient care.

CMS has proposed to measure quality of care using nationally recognized measures in five key domains: patient experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly health. These measures are aligned with the measures in other CMS programs such as the Electronic Health Records (EHR) and Physician Quality Reporting System (PQRS). An ACO that successfully reports the quality measures required under the Shared Savings Program would be deemed eligible for the PQRS bonus.

ACOs may not participate, however, in any other shared savings program or demonstration under the Center for Medicare and Medicaid Innovation or Independence At Home Medical Practice pilot program to ensure that savings are not counted twice.

If an ACO is already comprised of a self-contained financially and clinically integrated entity that has a pre-existing board of directors or other governing body, the ACO need not form a separate governing body or create a new legal entity. The

existing entity, however, must be recognized under applicable State law, be capable of receiving and distributing shared savings and repaying shared losses, and meet the other ACO functions identified in the statute.

Health care providers have reported that an important barrier to improving care coordination is lack of information. While they may know about the services they provide to the beneficiary, they don't know about other services provided to the beneficiary. To better treat patients and to coordinate their care, ACOs would be able to request claims information about their patient from CMS. Before doing so, ACOs must notify a beneficiary in writing that it would request the beneficiary's claims information from CMS.

ACOs must allow beneficiaries to opt-out of having their claims information shared with the physician and the ACO. This opting out of having claims information shared, however, does not affect the patient's participation in the ACO or CMS's use of the patient's data for purposing of assessing quality or cost measures. This notification must happen the first time the ACO cares for the beneficiary.

**Thank you for viewing this month's  
LGT Physician's View Point Newsletter**

**If you have any questions concerning topics covered in  
this issue please contact you LGT Professional today.**

*The Power of the Right People Beside You™*

**© 2011 Lane Gorman Trubitt, PLLC**  
Accountants & Advisors  
[www.lgt-cpa.com](http://www.lgt-cpa.com)

2626 Howell Street Suite 700  
Dallas, TX / 75204