Since 1966, Medicare has provided government health insurance for senior citizens. It provides seniors living in the United States with predictable health care for physicians’ services, hospitalization, and outpatient services. But as we are all well aware, health care has changed dramatically since 1966, and the Medicare program has changed as well.

Providers once were allowed to charge their standard charges and were profiled on those charges. Now we have a system in place that sets all of the fees charged. This system is known as the Resource-Based Relative Value Scale (RBRVS). Medicare has a set budget, and that money is allocated in a systematic way for administration and benefits. The RBRVS, coupled with the conversion factor and geographic adjustment factors, is what determines the fee schedule for the various services and procedures covered under the program. Every December, providers get the fee schedule for the following year and are given an opportunity to be participating or nonparticipating for that year.

**The Good:** The fee schedule, payment policies, and edits are published and fully disclosed. Some private insurance plans do not disclose their fees or payment policies, and providers must guess about such issues as global periods, payment edits, and the accepted use of modifiers.

Provider groups are included in the process for updating the codes, the RBRVS, and payment policies. APMA has expended much time and energy over many years to influence those systems that affect payment and payment policies.

**The Bad:** This government bureaucracy sometimes sets policies about which we disagree, and the system is resistant to change. For instance, the system for determining the conversion factor each year involves a complicated formula that is based on the gross domestic product (GDP) and is called the sustainable growth rate. For calendar year 2002, the calculation called for a decrease of 5.4 percent in the conversion factor. This is primarily due to the current economic recession. We know full well that the cost of practice has not decreased, and the costs of office space, employee salaries, and medical supplies have not gone down.

APMA, as well as many other medical associations, has called for the elimination of this 5.4 percent decrease, and a bill has been introduced in Congress to cut the decrease to 0.9 percent. At this time, the outcome of that legislation is uncertain. APMA has used its e-Advocacy site to lobby members of Congress for the change.

**The Ugly:** APMA and other associations have been frustrated for years by payment policies that simply do not make much sense in clinical practice. Local policies often vary from carrier to carrier on such issues as what qualifies a patient for routine foot care and what codes to bill for injecting a neuroma.

**The Reality:** APMA knows the Medicare system inside and out. We stay involved with Current Procedural Terminology (CPT) to ensure that codes exist to allow us to bill for the services we render. We stay involved with the Relative Value Update Committee (RUC) and the Practice Expense Advisory Committee (PEAC) to ensure that the services we render are appropriately valued. We meet with CMS (formerly HCFA) on a regular basis regarding issues affecting the profession.

APMA assists state associations with Medicare payment issues, and we have an annual Carrier Advisory Committee (CAC) meeting to allow all of the state CAC representatives to meet, share ideas, and learn about the Medicare payment issues affecting the profession. We publish *Coding Alert*, a newsletter aimed at keeping members informed about coding issues.

Medicare Part B data (BMAD), which is the report on which codes are billed in what frequency and on the dollar amount paid out for those codes, with a state-by-state breakout, is now on our Web site. We publish regular updates on Medicare rules in the *APMA Alert*, the *APMA NEWS*, and on our Web site.

The reality is that Medicare is the single biggest payer of health services in the United States, and it affects virtually every podiatric medical practice.

APMA is involved on a daily basis to see that it maintains access to the processes of the system and that the system continues to be relevant to clinical practice as much as possible. We never want Medicare payments to be reduced, unless our costs for rendering care actually go down.

APMA will maintain vigilance in its efforts to make Medicare better for DPMs and the patients we serve.

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