

# ALERT

## Proposed 21.2% Reduction for the Physician Fee Schedule is Frozen

The 2010 Federal Register that announced the Physician Fee Schedule (released on 10/31/09) included a comment period through 11/25/09. Legislation was passed to the Senate to halt the reduction after the House approved the postponement as well. The reduction is currently frozen until 2/28/2010.

### 2010 Annual Participation Enrollment Program Extension

Because of the delay in the 2010 fee schedule, Medicare (CMS) has extended the 2010 annual participation enrollment program end date. The enrollment period now runs from November 13, 2009- January 31, 2010. Medicare contractors will accept and process any participation elections or withdrawals made during the extended enrollment period that are post marked on or before January 31, 2010.

### Consults Cut Moving Forward

While the American Medical Association (AMA) met with senior CMS staff to discuss the concerns related to the elimination of the consultation codes, their concerns fell on deaf ears and the elimination is moving forward.

- Effective for dates of service on or after January 1, 2010, local Part B carriers and/or A/B Medicare Area Contractors will no longer recognize AMA CPT consultation codes (ranges 99241-99245 and 99251-99255) for inpatient facility and office/outpatient settings where consultation codes were previously billed.
- Physicians who bill a consultation after January 1, 2010, will have the claim returned with a message indicating that Medicare uses another code for the service.



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- "Conventional medical practice" is understood to be the action of physicians making a referral and physicians accepting a referral would then document the request to provide an evaluation for the patient. Physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician in order to promote coordination of care.
- In the inpatient hospital setting and nursing facility setting, any physicians and qualified nurse practitioners who perform an initial evaluation may bill an initial hospital care visit code (CPT code 99221 - 99223) or nursing facility care visit code (CPT 99304 - 99306), where appropriate.
- The principal physician of record (the admitting physician) will append modifier "-AI" (A plus the letter "I") Principal Physician of Record, to the E/M code when billed. This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care, i.e. what used to be known as a consult. However, claims that include the "-AI" modifier on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected and returned to the physician or provider.
- In all cases, physicians will bill the available code that most appropriately describes the level of the services provided.
- CMS has posted very specific guidance about Observation (CPT codes 99234-99236) coding.
- Emergency department (ED) visits (codes 99281 - 99288) which occur when a physician bills for emergency department services provided to patient by both patient's personal physician and emergency department (ED) physician: If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician



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does not come to the hospital to see the patient, but only advises the ED physician by telephone, then the patient's personal physician **may not bill**. If the ED physician requests that another physician evaluate a given patient, the second physician should bill an emergency department visit code, not a new patient outpatient code. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.

- A new patient is a patient who has not received any professional services (E/M or other face-to-face service) from the provider or a member of their specialty in the practice within the previous three years. This means that a provider may not bill a new visit for a consultation/evaluation of a new problem.
- There is specific information on how to bill for a consultation if Medicare is the secondary payer ("MSP"). Please review the transmittal if you run across these.

In the Medlearn Matters article,\* CMS reviews the times for Prolonged Services (99354-99357) for the codes now used for what used to be consults. If a provider provided counseling to a patient and time was a dominant factor in the visit, the consult codes had very long time frames for Prolonged Services to kick in---but visits do not. For example, for a 99245, more than 50% of an 80-minute visit extending to over 110 minutes would have qualified for Prolonged Services. But, with a 99205, this would be a 60 minute visit extending to 90 minutes. Remember that more than 50% of the visit must be spent counseling and that the counseling time and visit time must be documented in the record along with the reason for counseling. Time is not the dominant factor of E/M coding, unless it is counseling or coordination of care.

### National Correct Coding Initiative Edits

CMS decided to give us a Christmas present this year; a last minute change to the NCCI data set. This update was released on 12/23/09 and includes an additional 951 active edit pairs and terminates 262 edit pairs.

\* *Medlearn Matters*. Retrieved December 29, 2009, from the Centers for Medicare & Medicaid Services website: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf>.

## **Healthcare Reform: Senate passes H.R. 3590, the 'Patient Protection and Affordable Care Act'**

On December 24, 2009, the Senate voted to approve H.R. 3590, the "Patient Protection and Affordable Care Act". The House and Senate will now convene a conference committee to negotiate the significant differences between their two bills.

## **CMS expands claim editing to meet Social Security Act Requirements for Ordering and Referring Providers.**

CMS issued a CR6417 (Change Request) that required Medicare to implement system edits to assure Part B providers and suppliers bill for ordered or referred items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services.

Beginning January 4, 2010, all providers that "order" or "refer" services for Medicare beneficiaries must be in the Provider Enrollment Chain and Ownership System (PECOS) system or claims will be rejected. Providers that have had recent enrollment interaction with Medicare may already be in the PECOS system. All providers who refer/order should verify their enrollment. Verification can be done by accessing their website at <https://pecos.cms.hhs.gov/pecos/login.do>.