

ALERT



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JANUARY 2010

CMS Holds Claims for 10 Business Days, Extends Participation Deadline

From The American Medical Association, posted Dec. 23, 2009

In December, Congress acted to avert the 21.2 percent Medicare physician payment cut and on December 19, 2009 the President signed into law the Department of Defense Appropriations Bill (H.R. 3326) which will stop the cuts until March 1, 2010. Other changes reflected in the 2010 Medicare Physician Fee Schedule final rule will still take effect on January 1, 2010, and may have a slight impact on the conversion factor used for the first two months of 2010. Similar to other years, since Congress acted so late in the year to avert the cut, the [Center for Medicare and Medicaid Services](#) (CMS) will hold claims for the first 10 business days of January (January 1 through January 15) for 2010 dates of service to allow its contractors time to update their systems and pay claims based on the updated rates. CMS does not anticipate any cash flow problems for physicians since by law no claims are paid prior to 14 days after receipt. In addition, CMS has extended the 2010 Annual Participation Enrollment Program end date from January 31, 2010, to March 17, 2010. Physicians still have time to consider their participation options with the Medicare program.

The effective date for any participation status change during this extension remains January 1, 2010, and will be in force for the entire year. Medicare contractors will accept and process any participation elections or withdrawals made during the extended enrollment period that are received or post-marked on or before March 17, 2010. CMS announced the claims processing delay and extended participation enrollment period in a December 21 communication that was developed prior to the Congressional action and, therefore, inaccurately suggests that payments may still be cut on January 21. The AMA is concerned that the announcement will prove confusing to physicians and has asked CMS to update and clarify the notice. If they do, the AMA will notify members.

NEXT

Medicare to Eliminate Consultation Codes

Effective Jan. 1, 2010, the [Centers for Medicare and Medicaid Services](#) (CMS) will eliminate the use of all inpatient and office/outpatient consultation codes. This includes inpatient codes 99251 to 99255 and outpatient/office codes 99241 to 99245. Instead of using consultation codes, providers should bill, as applicable:

- Initial inpatient hospital care: 99221 to 99223
- Subsequent hospital care: 99231 to 99233
- Initial nursing facility care: 99304 to 99306
- New patient office visit: 99201 to 99205
- Established patient office visit: 99211 to 99215

To distinguish admitting physicians from consulting physicians who will also be using initial hospital care codes, CMS created Modifier – A1 – Principal Physician of Record to be used by the admitting physician. The admitting physician will append the modifier to the initial care code, which will identify the physician as the admitting provider of record. Other physicians will bill the applicable initial care code without a modifier when a patient is seen for the first time during that hospital admission. For office consultations, physicians will now bill either a new patient visit code if the patient meets new patient criteria or an established patient visit code if they do not meet new patient criteria (for example, if the patient was seen sometime in the last three years). As part of this change, CMS will increase work relative value units (RVUs) for initial hospital and nursing facility visits by about three percent and increase work RVUs for both new and existing office visit codes by about six percent. There also has been a nominal increase in work RVUs for surgical services with a 10- or 90-day global period. For inpatient and office visits, physicians will need to meet the applicable evaluation and management (E&M) coding and documentation requirements for new and established office visit codes and initial and subsequent hospital visit codes. Medicare will not convert billed consultation codes to the appropriate office or inpatient codes. Claims using consultation codes will be rejected.

NEXT

CMS G-Code Modification for Electronic Prescribing

Because of the well documented cost and safety benefits of e-prescribing, CMS has made recent alterations to the Electronic Prescribing Incentive Program to ensure e-prescribing is adopted by as many eligible professionals as possible. See below for specific changes being implemented for 2010:

2009: There were three G-codes related to different e-prescribing scenarios.

2010: There is only one G-code (G8553) to show a visit resulted in an e-prescription.

2009: Providers were required to enter respective G-codes for e-prescribing events in 50% of eligible ambulatory visits.

2010: Providers are only required to enter the new G-code 25 times during the calendar year.

2009: The reporting process needed to be conducted through the current claims-based reporting mechanism.

2010: In addition to claims-based reporting, any Registry or EHR which has qualified for 2010 PQRI may be used for reporting.

2009: There were strict limitations on which providers are eligible.

2010: The incentives are now extended to professional services furnished in skilled nursing facilities, domiciliary care, and the home care setting

For more information regarding Electronic Prescribing - watch the short video posted on our website at <http://www.doctorsaccess.com> and register to attend our next online informational seminar at <http://doctorsaccess.webex.com>

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