

## Changes to Medicare Reimbursements

Tammi Schaper

There has been considerable confusion over what has happened to Medicare physician payments on January 1. Despite the announcement of a halt in Medicare cuts for 2007, there are 3 different events that have occurred on January 1 (in addition to the Deficit Reduction Act—see below) that will affect how much physicians get paid for providing services to Medicare patients:

**1. Inflation Adjustment:** For Calendar Year 2007, the Medicare Economic Index adjustment should have been an across-the-board 2.1% increase. Because the growth in Medicare Part B spending during 2006 increased much more than had been budgeted, the MEI increase was eliminated and instead, CMS stated that physician payments would have to be decreased by 5.1% in 2007 in order to stay within projected budget targets.

As a consequence of Congressional intervention, however, the projected negative 5.1% adjustment has been repealed and instead, the Conversion Factor (CF) for Medicare will be frozen for 2007 at the 2006 level.

**2. Five-Year Update of the Work RVU:** By law, CMS is required to review the physician work RVU (pwRVU) every 5 years to determine whether there have been any significant changes that result in physicians spending more time or less time providing a particular service than had been expected. During 2006, CMS conducted the 5-year RVU review of EVERY code.

As a result of this review, some rather significant changes in the work values of hundreds of CPT codes have occurred beginning January 1.

In a Federal Register notice, CMS includes a document



that estimates the impact RVU changes will have on various specialties. The following numbers are based upon national averages and may vary somewhat in your region. Here are some selected specialties:

Anesthesiology	- 6%	Emergency Medicine	+7%
Family Medicine	+5%	Pathology	- 5%
Radiology	- 5%	Internal Medicine	+5%

**3. Budget Neutrality of RVU Changes:** Congress, in mandating the 5-year RVU updates, also stipulated that if the updating process resulted in an INCREASE in aggregate Medicare expenditures for that year in excess of \$20 Million, the agency had to adjust payments to make the changes “revenue neutral”. According to CMS, Medicare expenditures will increase \$4 billion in 2007 because of the physician work RVU updates.

Therefore, by law, CMS was required to make adjustments to nullify this increase in aggregate spending. (Rearranging the furniture?). CMS decided to meet the Revenue Neutrality requirement by adjusting the mathematical equation that leads to the Fee Schedule amount for each code.

Because of each of the above changes, it is extremely difficult to know how Medicare’s payments for a specific code will be affected. For more detailed information about how this change will affect your practice, contact PBN’s Client Services Department.

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## Deficit Reduction Act—Impact & Status

Sarah Mountford

The 109<sup>th</sup> Congress failed to block the Deficit Reduction Act cuts, which now go into effect on January 1, 2007. These cuts, in addition to the changes in Practice Expense and Work RVU methodology, add up to bad news for imaging codes.

Section 5102(b) of the

DRA limits payments on the Technical Component payment rates for imaging services delivered in physician offices or imaging centers.

TC reimbursement will be capped at the lesser of the Medicare physician fee schedule payment rate or the Ambulatory Payment Category (APC) under the

Hospital Outpatient Prospective Payment System. These TC payment reductions apply to X-Ray, U/S (including echocardiography), nuclear medicine (including PET), MRI, CT and fluoroscopy.

Savings from the ‘lower of the two’ cap and the multiple procedure reductions already in effect go

back to the federal fund, and are expected to be \$2.8 billion over the next 5 years.

There is some hope that the 110<sup>th</sup> Congress will proceed with revisions to the DRA, though the ACR warns that many in Congress believe that imaging is still too profitable an area, and might seek further offsets from imaging for other programs.



## Coding Changes for 2007

Sarah Mountford

In 2007 CPT did its usual amount of rearranging, deleting, renumbering and rewording, in addition to the creation of well over 100 new codes. Technically there are 172 new CPT codes in 2007, with 88 additions to the Category III code series. It should be noted that 33 of the new codes are due to a renumbering of the Radiology section in which the code

language did not change. (e.g. '06 CPT 76091—bilateral mammogram—becomes code 77056 in '07.)

Other changes of note are the 14 new cardiac surgery codes, including the deletion of 4 previously used pace-maker codes. In Vascular surgery, we get 5 new thromboendarterectomy CPT's which provide new coding depth to procedures done on arteries of the lower

extremities. There are also 6 additions to bypass coding.

A handful of additions to GI surgery, OB / GYN, Moh's surgery and a new series of ventilator management codes (94002 –94005) round out the list. Nearly every specialty will have at least a few new codes or changes to the language of old codes in their sections, so be sure to update your encounter forms and super bills.

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## When is a new patient new?

Nora Kreader

One of the most common questions providers ask about Evaluation and Management coding is how to properly classify patients as new versus established.

A new patient is one that has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. These services would be coded and

billed as 99201 – 99205 E&M range. However, if the patient has received such services they would be considered an established patient. Billing and coding for these services would be from the 99211 – 99215 range.

The specialty of the physician is a critical factor not to be overlooked. Take, for example, a patient who has received both an anesthesia service as well as

a pain management service at a later date from physicians within the same group practice. If the pain management provider is designated as an interventional pain specialist (09), while the anesthesia provider is classified as an anesthesiologist (05), the patient could be billed as a new patient for the E-M portion of their pain management service.

## Consultation Rules

Nora Kreader



Consultation coding is confusing. So, what is a consultation? A consultation is when one physician is asking another to evaluate a patient and provide advice, opinion, or recommendation in relation to a specific problem. There is no intent to transfer the patient's care although diagnostic services

and/or treatment may be initiated during the consultation service. Remember: if the intent is to transfer care of a patient, no consultation is indicated. Your opinion and/or recommendation is not being sought, it is simply your expertise in addressing the problem.

Four key factors determine

whether a consultation exists for coding and billing purposes. These are the "4 R's" - Request for opinion, Reason for opinion, Rendering of opinion, and Report of opinion back to requesting physician.

A request for an opinion can be either written or verbal, and both physicians should

## Consultation Rules

### Continued

document the request in the patient record, reflecting the reason your opinion was sought.

Once the patient has been evaluated and you have determined your recommended treatment plan, you are rendering your opinion. This must be provided back to the

requesting physician in writing. In the case of a shared record (i.e. an inpatient hospital chart) the documentation can simply be in the shared record. For all other cases a dictated report or letter must be sent to the requesting provider.

The report should outline the evaluation of the patient,

findings, opinions and any recommendations.

So, you were asked for your opinion, evaluated the patient and made recommendations, and provided a written response. Otherwise, the appropriate non-consult E&M level of service should be billed.

**Medical Trivia**  
The scientist, Sir James Black, won the Nobel Prize in Medicine in 1988 for his role in discovering what?

Beta Blockers

## Client Services

### Michelle Daum

PBN's very capable Client Services Team is the primary point of communication for providers and practice managers.

Tammi Schaper, PBN's compliance officer and Quality Management Representative for PBN's ISO process, leads the Client Services department. Her 23+ years in the medical billing business make her a great resource for clients.

Phyllis Morris, Manager of

Customer Service, manages our Help Desk for patients. She also works with clients of various specialties.

Sarah Mountford, CPC, RCC, PBN's Radiology and Surgery Client Liaison, has been with PBN for 8 years and is an expert in coding interventional procedures.

Amie Hamtil, CPC-EMS, CMRS, the newest member of the team, works with multiple specialties. Her 15+

years experience in medical office procedures and management make her a great asset to her clients.

Nora Kreader, CPC, handles anesthesiology and emergency medicine clients. Her efforts have helped clients improve their revenue per CPT.

Our highly knowledgeable team of professionals can assist you in improving efficiency in your practice.



Tammi, Phyllis, Sarah, Amie, and Nora

## New Medicare Claim Forms (NPI Box)

### Dave Hahner

On October 2, 2006, CMS sent a notice concerning the new method to bill the Medicare Fee-For-Service program using a legacy and NPI combination of provider identifiers.

After May 23, 2007, only claims submitted with new formats and NPI numbers will be processed.

Though one number for everyone sounds good, no

provision has been made for a central database of NPI numbers (like is available for UPIN's). Providers (or their billing agents) must do the following:

- Get their own NPI # and distribute it to all payers with their legacy numbers for cross reference.
- Get all NPI numbers for referring providers and

facilities and include them on claims as appropriate.

- Put your NPI number on all correspondence (referring forms, etc.) and require all providers and facilities you work with to do the same.

Having NPI numbers on your claims will be critical to getting them paid in a timely manner. PBN is updating all client databases with the appropriate NPI numbers.

**For any questions, contact your Client Liaison**

or e-mail us at [info@pbnmed.com](mailto:info@pbnmed.com)



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## From Jud's Desk

Welcome to the first edition of PBN Provider News. We're pleased to offer you a small selection of short articles that we hope you will find helpful for your practice. We will publish this quarterly, and you can receive it via mail or e-mail. If you'd like to receive it electronically, just e-mail us at [info@pbnmed.com](mailto:info@pbnmed.com).



Recently, we conducted our first **Client Satisfaction Survey**. The results gave us excellent feedback including some opportunities where we can provide better services. Contract management and credentialing are areas that our clients would like us to develop more fully. Also, coding feedback and education are topics where more specialized training from our staff would be valued. PBN is committed to client satisfaction. As such, we have already begun implementing the strategies we developed as a result of your feedback. If you have a particular interest in either area, or any other topic on the survey, please let your client liaison or me know so we can discuss it with you personally.

**“Our dedicated staff works diligently to exceed industry benchmarks for DSO's and Percent over 120.”**

As continuous improvement is one of our core values and an integral part of our ISO processes, it is important for you to provide us with your opinion. It guides us to provide more resources to enhance the services you value most. Feel free to call me with your thoughts or ideas on anything we can do to better serve your needs. Talk to you next quarter.

All the best,  
Jud