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CMS MAY CUT PAYMENT FOR PHYSICIANS SERVICES BY 21.2%

By law, Medicare Physician Fee for Service (MPFS) payment rates are adjusted annually, and recent practice has been for CMS to slash them each year before Congress acts, usually at the last minute, to forestall the drastic cuts. Next year will be no exception, at least as far as CMS action is concerned; however, CMS said that the rates will only be reduced by 21.2 percent, rather than the 21.5 percent that had been earlier projected for 2010. The difference is due to updated data on CMS spending for physicians' services. CMS made the announcement Oct. 30 in the Federal Register.

The law requires CMS to adjust MPFS payment rates annually based on an update formula that applies the Sustainable Growth Rate (SGR) adopted in the Balanced Budget Act of 1997. Since 2002, the payment rates have been reduced by CMS every year. In 2003, CMS took administrative steps to avert an actual reduction in payments, and from 2004 through 2009, Congressional action prevented the proposed reductions from taking effect. Unless Congress steps in, the rates will be reduced for services performed on or after Jan. 1, 2010.

For more information, read the [CMS Press Release](#) and/or the [Federal Register CY2010 Listing](#)



CMS TO PHASE OUT CONSULT PAYMENT FOR PHYSICIANS; SWITCH LIKELY TO HELP PCP's, HARM SPECIALISTS

Effective Jan. 1, 2010, CMS will no longer accept codes for medical consults (99241-99245 and 99251-99255); instead requiring physicians to code for either a new or established patient (99201 – 99205 and 99211 – 99215). The RVUs for new and established patients will increase by 6 percent in 2010. This may benefit primary-care physicians, but could represent a pay cut for specialists — who will now be required to bill only a new or established patient, instead of a consult. CMS defines a new patient as one who has not received a service from a physician (or another physician in the same specialty, and the same group) in the past three years.

For more information, read the [CMS press release](#) or see the [Federal Register CY2010 Listing](#) on page 174. The final rule with comment will publish Nov. 25, 2009, in the *Federal Register*.





PHASE 2 IMPLEMENTATION OF CMS PART B CLAIM EDITING MAY CAUSE SOME CLAIMS TO BE REJECTED

Phase 2 of the Expansion of Scope of Part B Claim Editing for Ordering/Referring Providers will go into effect Jan. 4, 2010. The change will effect claims for ordering or referring providers and could result in substantial numbers of claims being rejected, the Centers for Medicare and Medicaid Services (CMS) said.

During Phase 1, which took effect last Oct. 5, received claims are edited through the Multi-Carrier System (MCS) to determine if the billed services require an ordering/referring provider. If that is the case but the ordering/referring provider was not listed on the claim, CMS processed the claim with Remark Code M68 – *missing/incomplete/invalid attending, ordering, rendering, supervising, or referring physician identification on the remittance advice.*

Under Phase 2, if the billed service requires an ordering/referring provider but none is present, the claim will **not** be paid. If the ordering/referring provider's NPI and name is reported on the claim, Medicare will verify this against their records in Provider Enrollment Chain and Ownership System (PECOS) to ensure the ordering/referring provider is enrolled and in a specialty eligible to order or refer.

If the ordering/referring provider is not in PECOS, the carrier will search its claims system for the ordering/referring provider information. If the search does not turn up any information on the ordering/referring provider, the claim **will be rejected**. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will also not be paid.

Note: If multiple Provider Transaction Access Numbers (PTANs) are associated to the NPI in MCS, Medicare contractors will use the first active PTAN with an eligible specialty to order and refer.

Providers submitting paper claims are advised not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.

Medicare enrollment can be verified by going to

www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage

The official CMS instruction, CR6417, can be viewed at:

<http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA6417.pdf>

Providers who order or refer wanting to verify their enrollment in PECOS may do so by accessing PECOS at <https://pecos.cms.hhs.gov/pecos/login.do> on the CMS website.

Instructions on how to use PECOS can be accessed at

http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS website.

