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PRACTICE MANAGEMENT NEWS

Physician Payment Rates for 2011

The Centers for Medicare & Medicaid Services revised the Medicare Physician Fee Schedule database to include revisions and significant statutory changes for physician payments in 2011. CMS indicated that all Medicare carriers should update their system to reflect the new payment schedule along with the 2011 relative values file to ensure that claims will be paid on time and at the correct rates with no adjustments or necessity to hold claims.

In addition, President Obama signed the Medicare and Medicaid Extenders Act of 2011 which provided a zero percent update to the MPFS on all claims with date of service from January 1 – December 31, 2011. While the update is zero percent – changes to the relative value units will remain budget neutral. With the budget neutrality, CMS had to make adjustments and revise the 2011 conversion factor to \$33.9764.

Below is the calculation for the average payment rate of CPT code 99213 which shows a 3.3 percent increase in reimbursement from 2010 to 2011:

Medicare National Payment for 99213

	2011	2010
Total RVU	2.03	1.81
Conversion factor	\$33.9764	\$36.8729
Payment	\$68.97	\$66.74
Increase	3.34 percent	

Visit the ACR website for more information on the updated 2011 payment rate or contact Melesia Tillman at mtillman@rheumatology.org.

2011 New Diagnostic Ultrasound CPT® Code

As of January 1, 2011, the diagnostic ultrasound code 76880 was eliminated and replaced with two separate CPT codes 76881 and 76882. These new codes should be used to report diagnostic ultrasound scans of muscles, joints, tendons, soft tissue in the extremities.

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Code Definitions:

76881 – Ultrasound, extremity, nonvascular, real-time with image documentation; complete

Code 76881 is a complete ultrasound examination of an extremity consists of real time scans of a specific joint that includes examination of the muscles, tendons, joint, other soft tissue structures and any identifiable abnormality.

76882 - limited, anatomic specific

Code 76882 refers to an examination of an extremity that would be performed primarily for evaluation of muscles, tendons, joints, and/or soft tissues. This is a limited examination of the extremity where a specific anatomic structure such as a tendon or muscle is assessed. In addition, the code would be used to evaluate a soft-tissue mass that may be present in an extremity where knowledge of its cystic or solid characteristics is needed.

The new codes for 2011 were separated to identify more specificity of the anatomical site. *Keep in mind if ultrasound guidance is necessary to guide injections or aspirations then CPT code 76942 would be used to report the procedure.*

Please contact the ACR coding specialist, Melesia Tillman, CPC, CRHC, CHA at mtillman@rheumatology.org for questions on coding and documentation guidelines.

Retroactive Payments for DXAs

The 2010 Medicare and Medicare Extenders Act signed by President Obama last month includes a provision requiring CMS to pay physicians for retroactive claims of DXA services provided between January 2010 and July 2010.

The retroactive payments were delayed last year due to a lack of funds but Congress has provided the necessary funds for CMS to reprocess about 350 million claims. Claims will be processed in the order there were received starting with those submitted January 2010.

In July 2010, the Patient Protection and Affordable Care Act had a mandatory provision for Medicare to pay an additional \$35 per DXA scan—making the national reimbursement rate increase from \$62 to \$98.

Please note: There has been no information as to when CMS will send out any checks but no action is required by physicians to receive the retroactive payments.

If you have any questions or need additional information, contact the ACR practice management department at (404) 633-3777.

ACR Participates in White House Forum on Delivery System Reform

On December 17, ACR President David Borenstein, MD, and Government Affairs Committee Chair Tim Laing, MD, attended a White House forum on Delivery System Reforms.

Ezekiel Emanuel, MD, PhD, who currently serves as Special Advisor for Health Policy at the Office of Management and Budget, invited health care providers and senior Administration officials, including Centers for Medicare & Medicaid Services Administrator Donald Berwick, MD, to participate in this forum. The discussion was an open dialogue around how providers can make hospitals safer and reduce re-admission rates and how to develop effective accountable care organizations.

Dr. Borenstein and Dr. Laing spoke about improved outcomes for patients with RA who see a rheumatologist early and how rheumatologists can prevent hospital admissions.

The ACR looks forward to continued dialogue to ensure CMS and other government agencies consider the important role rheumatology plays in delivering high valued health care.

Regence Looks to ACR Regarding Pegloticase

Regence has requested that the College review their policy for the use of pegloticase as well as comment on adding this drug to their preferred drug list. The insurance subcommittee is reviewing the policy and will letter submit a response letter to Regence.

ACR to Comment on New Cigna Policy

The ACR was made aware of Cigna's new "fail" first policy effective January 1, 2011—this new policy requires a patient to first fail Humira then Enbrel before access to any infusible product.

The ACR insurance subcommittee is reviewing the policy and will send a letter to Cigna as this policy places heavy restrictions on physicians and interferes in the decision-making process of the doctor-patient relationship.

Cognitive Specialties Unite In New Coalition

A coalition has been developed to promote the importance of specialties in providing high-valued patient care. On January 13, the coalition hosted a roundtable discussion with U.S. House of Representatives members and staff to discuss the importance of specialty care. The discussion focused on the additional training and expertise of specialists, cost effectiveness of specialty care, improved patient outcomes and the impact the elimination of consultation codes is having on patient access to care. In addition to the ACR, other members of the Cognitive Specialty Coalition include: the American Academy of Neurology, American Association of Clinical Endocrinologists, Infectious Diseases Society of America, North American Neuro-Ophthalmology Society and The Endocrine Society. The American Medical Association attended the briefing to demonstrate their support of reinstating the consultation codes.

The coalition continued their efforts by educating House Ways & Means and Senate Finance Committee staff on the impact of the elimination of consultation codes and requested congressional action to require the Centers for Medicare & Medicaid Services to reinstate these codes.

ACR Testifies at MedPAC Meeting

On January 14, Tim Laing, MD, Government Affairs Committee Chair, testified before the Medicare Payment Advisory Commission. MedPAC is an independent congressional agency established to advise Congress on issues affecting the Medicare program.

Dr. Laing focused his testimony on the value of cognitive specialties. He highlighted the impact that CMS' decision to eliminate consultation codes will have on the workforce in already underrepresented cognitive specialties.

Other members of the Cognitive Specialty Coalition testified on the value of these various specialties and requested the MedPAC further review the impact of eliminating the consultation codes.

ACR Submits Comments on 2011 Medicare Physician Fee Schedule Final Rule

In November 2010, the Centers for Medicare & Medicaid Services released the 2011 Medicare Physician Fee Schedule final rule detailing Medicare physician payment policies for 2011. The rule includes the annual update to the Medicare payment schedule as well as implementation of a number of provisions of the Patient Protection & Affordable Care Act.

On January 3, the ACR submitted comments on the rule expressing patient access issues resulting from the elimination of consultation as well as concerns and recommendations to improve the PQRI program. Read the letter [here](#).

Avoid 2012 e-RX penalties by reporting in 2011

CMS plans to use 2011 data to determine 2012 penalties for e-prescribing. In order to avoid a penalty for e-prescribing in 2012, physicians must now engage in claims-based reporting of G-code G8553 10 times between January 1 and June 30. Penalties will not apply to physicians (or group practices) where less than 10 percent of their allowed charges for this come frame are comprised in the 2011 e-RX measure.

Visit www.rheumatology.org/HIT for more information on the 2011 CMS e prescribing program and how to avoid financial penalties of up to 1.5 percent on your Medicare Part B PFS.

CMS Reset PECOS Ordering/Referring Edit

CMS has withdrawn its notice to begin rejecting claims on January 3, 2011 for certain Part B services from providers who do not have an enrollment record in the Medicare Provider Enrollment, Chain and Ownership System. CMS has stated that no decision has been made when they will begin to reject claims but they will give providers ample notice before rejections begin.

CMS is still in Phase 1 of this policy and will continue to process claims until an official implementation date is established. However, claims that are received for a provider without an approved enrollment record in PECOS will be processed with one of the most appropriate remark codes N264 or N265 on the remittance advice.

- N264 *Missing/incomplete/invalid ordering physician provider name*
- N265 *Missing/incomplete/invalid ordering physician primary identifier*

Physicians and other health care providers should take this opportunity to start or complete their Medicare enrollment process. Providers can also review Medicare's enrollment record or view their status on CMS' [Ordering and Referring Report](#). For questions and additional information on PECOS, contact Antanya Chung at achung@rheumatology.org.

They're Back!

Congress is back in Washington and now is a great time to reach out to your legislators and introduce yourself, the value of rheumatology and the issues that matter to you most.

Most members of Congress, new or experienced, know little about the rheumatology subspecialty and the unique issues facing rheumatology professionals and patients. That is why it is critical that you educate your elected officials on the importance of specialty care and the impact arthritis and rheumatic diseases have on one's quality of life. Introduce your members of Congress to the value of rheumatology using the [ACR's Legislative Action Center](#).

2011 is Your Year to RheumPAC

The new Congress will make significant health policy decisions that will affect the rheumatology profession and patients. So how do we ensure that key decision makers understand the unique issues facing the rheumatology community? Through RheumPAC.

RheumPAC, the ACR's non-partisan political action committee, provides opportunities for the College to educate Congress on the importance—and especially the value—of rheumatology.

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The ACR uses one-on-one meetings and small events to discuss:

- Appropriate reimbursement for specialty care through reinstatement of consultation codes
- A permanent repeal of the SGR formula
- Improvements to the health care law
- Funding of the pediatric loan repayment program
- Continued access to bone density scans
- Increased funding for arthritis research

Make 2011 your year to RheumPAC. To learn more about RheumPAC or contribute online, please visit www.rheumatology.org/RheumPAC.

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