Part B Insider (Multispecialty) Coding Alert

Fee Schedule: Let Docs Choose Level For 'Welcome to Medicare' Exam Codes, AMA Urges

With the **Centers for Medicare & Medicaid Services** planning to issue its final 2005 **Physician Fee Schedule** rule on Nov. 1, physicians are holding their breath for some changes from the proposed rule.

In comments submitted in late September, the physician societies urge CMS to:

1. Account for increased utilization of physician services that will result from the preventive benefits that Congress is adding to Medicare. Otherwise, under the sustainable growth rate formula the increased spending will lead to deeper cuts in physician rates in the future, warns the **American College of Physicians**. The new preventive services will trigger increased visits, lab tests, diagnostic tests and procedures. Other services that will raise spending include professional shortage area payments, clinical trial costs and the face-to-face requirement for any durable medical equipment, prosthetics, orthotics or supplies prescription, notes the **American Medical Association**.

   ACP and the AMA also asks CMS to remove drugs from the SGR. The AMA notes that CMS treats drugs as "not a 'physician' service" elsewhere.

2. Reinstate the six minutes for discharge management that it removed from facility-based RVUs for gastrointestinal endoscopy code 99238. In the proposed rule, CMS said it would remove discharge management from all procedures with 0-day global periods, while keeping it for codes with 10-day and 90-day periods. The missing six minutes account for half the clinical staff time in 99238, complains the **American Society for Gastrointestinal Endoscopy**.

3. Scrap the planned code for the 'Welcome to Medicare' exam. CMS should instead allow physicians to bill for the exam using a preventive medicine service new or established patient code (99381-99397) along with EKG code 93000, with the appropriate "V" code, such as V70.0. Descriptors for the currently non-covered 99381-99397 are purposely vague and the introductory text says the extent of the services depends largely on the patient's age, the ACP notes.

   Also, CMS should clarify whether a physician without an EKG in the office is prohibited from providing this initial exam, or whether he/she must simply attach a modifier such as -52 (Reduced services) to the exam code. CMS also should rescind its proposal to restrict coverage for evaluation and management visits on the same day as preventive physical exams to a level-two visit, ACP insists.

4. Scrap the requirement for doctors to see all patients face-to-face before prescribing any DMEPOS. For a patient with permanent colostomies, a doctor would have to require visits or make housecalls "to fill periodic supply needs," ACP notes. CMS should develop more clinical criteria for prescribing DMEPOS for which there's a demonstrated need, and identify DMEPOS items for which there's a permanent need that doesn't change.