Part B Insider (Multispecialty) Coding Alert

MEETINGS: CMS Doesn't Feel Your Part D Pain

Nurse practitioners soon may be able to bill for their own services in hospitals

The **Centers for Medicare & Medicaid Services** (CMS) brushed off physicians' concerns about the Part D drug program at the May 22 meeting of the **Practicing Physicians Advisory Council**.

PPAC had recommended that CMS keep track of how much time physicians spend appealing Part D drug coverage decisions on behalf of their patients. PPAC also wanted CMS to monitor the time and costs of care related to coming up with substitute medications for drugs that were denied.

CMS responded that the Part D drug program was designed to minimize the amount of time physicians would have to spend coming up with substitute drugs. The agency didn't think it was worthwhile to track this problem, since it obviously didn't exist.

Also at the May 22 PPAC meeting:

• CMS said it was working to change the section of the **carrier manual**, which now says that nurse practitioners can't bill for their own services in the hospital. Instead, currently, the hospital or other facility must bill for the NP's services.

• **Neurosurgical codes** 61630-64642 didn't have relative value units (RVUs) in the physician fee schedule rule, but CMS will fix this in a June proposed rule.

• Medicare will work on **expanding diabetes self-management training** (SMT) to include some diabetics whose disease isn't described by ICD-9 codes 250.00-250.93, such as diabetes caused by pancreatectomy or hemochromatosis.

• The **American Academy of Family Physicians House of Delegates** passed a resolution asking CMS to **reevaluate a requirement** that practitioners at Critical Access Hospitals (CAHs) must respond to emergency patients within 30 minutes. CMS officials may change the language to make this requirement easier to comply with.

• Hospitals may be able to **provide continuing medical education** (CME) without falling afoul of the Stark self-referral law, which prohibits financial relationships with physicians who refer patients. CMS will state in its Stark final rule that CME programs should be structured to avoid Stark problems.

• Some **pay for performance (P4P) programs** will be directed toward small practices, CMS said in agreement with a PPAC recommendation. CMS will also work on coming up with incentives for patients to comply with the treatments they receive, so physicians don't suffer for patients' shortfalls. But CMS won't measure the cost of collecting data for P4P.

CMS has contracted with two software vendors, **Ingenix** and **Medstat**, to come up with **"episode groupers"** that can join together a group of physician claims to look at one particular patient's illness and how the physician treated it.