# Part B Insider (Multispecialty) Coding Alert

## PHYSICIAN NOTES: Physician Cuts Go Ahead As Planned, CMS Reports

**Voluntary reporting program will be less complicated, notes ACP**

Since Congress failed to pass a final budget for 2006 before it recessed for the year, the **Centers for Medicare & Medicaid Services** had no choice but to go ahead with the 4.4 percent cut to your reimbursement, CMS says in a press release.

Also, because the budget didn't pass, the base composite rate paid to end-stage renal disease facilities won't increase from 2005. The budget would have raised that rate 1.6 percent. CMS' moratorium on new specialty hospitals, due to expire on Feb. 16, would have been extended under the budget for another six months pending a report to Congress.

**In other news:**

• Physicians rejoiced when CMS simplified the new Physician Voluntary Reporting Program (PVRP), according to a press release from the **American College of Physician**. On Dec. 27, CMS announced that instead of the 36 measures it wanted you to report on, it would only look at 16 "starter set" measures instead, and only seven would apply to internal medicine doctors, instead of the 22 from the original set.

Six out of those seven measures were endorsed by the **Ambulatory Care Quality Alliance**, and they include measures relating to diabetes, congestive heart failure, post-myocardial infarction beta-blocker use, and the risk of falling. Medicare won't pay you for reporting these codes, but they are likely to form the template for a pay-for-performance program that will affect your reimbursement, ACP notes.

• CMS will expand cardiac rehabilitation services to include patients who have had heart valve repair or replacement, percutaneous transluminal coronary angioplasty, and heart or combined heart-lung transplants. Also, CMS proposes to include medical evaluation, education, and nutrition services in cardiac rehab services.

• CMS scraps the HIPAA contingency plan for incoming claims in Transmittal 802, dated Dec. 30. Carriers will reject any electronic claim that doesn't comply with the HIPAA standards. Carrier software also should collect claim adjustment reason codes and adjustment amounts from primary payors when Medicare is the secondary payor.

• CMS provides instructions on how to bill non-paying code **V2788 for** the non-covered charges associated with insertion of a presbyopia-correcting lens in Transmittal 801, dated Dec. 30.

• If you write to your carrier and express "dissatisfaction" with some aspect of a denial, the carrier will regard this as a request for an appeal, according to Transmittal 87, dated Dec. 30. Or if the overpayment was identified outside the appeals process, your protest will be interpreted as a request for redetermination.