Part B Insider (Multispecialty) Coding Alert

PRIOR DETERMINATION: More Certainty About High-Cost Items Could Be On Its Way

Your carrier has 45 days to decide on pricey items, but may respond more quickly

When patients sign an advance beneficiary notice (ABN) for big-ticket items or services, they're playing Russian roulette on Medicare's wheel. But soon you may be able to take the uncertainty out of it for your practice and your patients.

The Medicare Modernization Act instructed the **Centers for Medicare & Medicaid Services** to come up with a prior determination process for "certain physicians' services," and the agency has finally stepped up. The CMS has unveiled its long-awaited "prior determination" system for the most expensive items and services.

Your carrier will let you know within 45 days whether Medicare will pay for a **service a physician** plans to provide, according to the proposed rule published in the Aug. 30 Federal Register (Vol. 70, No. 167, pp. 51321-51325). Your carrier may respond more quickly when the service is urgent, CMS adds.

CMS also said it would impose "reasonable limits" on spending for the high-cost items in the pool.

CMS plans to establish a pool of the 50 services with the highest allowed charges, which physicians provide at least 50 times per year. But the pool won't include any services which have a local or national coverage determination that provides clear enough information to let the beneficiary or physician know if the service will be covered. If you ask for a determination on such an item, your carrier will refer you to the policy. The list of 50 services will be the same across the country, except in cases where a clear enough local policy exists in one area and not in others.

CMS says it considered national data on physicians' services, including payment amounts and utilization rates, in choosing services for the pool. But the agency decided not to consider whether a service has a high denial rate.

The pool may grow in the future if CMS sees the need. The agency also will allow prior determination for plastic and dental surgeries that have average allowed charges of at least $1,000 each. The services in the pool tend to be non-emergency surgical services performed in an inpatient setting, so beneficiaries should have enough time to ask for a prior determination.

Perspective: "For those people who actually are doing those top 50 services, this will be helpful," because "it can be a little bit of a shock" if an expensive procedure turns out not to be covered, says **Quin Buechner**, a consultant with **ProActive Consultants** in Cumberland, WI. But he says this doesn't help most physicians who are performing procedures without knowing whether Medicare will cover them. He says Medicare should offer prior approval for frequently denied services.

You have until Oct. 31 to comment on the proposal, and you can do so at www.cms.hhs.gov/regulations/ecomments.