



Reimbursement & Coding News

January 25, 2010

Santa Clara County Medical Association/Monterey County Medical Society

Since Medicare Secondary Payer (MSP) will not pay for consults, how do you bill and get paid for the consult you billed to the patient's primary carrier? [MLN Matters article MM6740](#), indicates the following:

"In MSP cases, physicians and others must bill an appropriate E/M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes," you should bill in one of the following two ways:

- Bill the primary payer an E/M code, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or
- Bill the primary payer using a consult code, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

To download the MLN Matters article MM6740 go to <http://www.sccma.org> and click the "Download" tab under Reimbursement.

DMHC Finalizes Timely Access Regulations

The California Department of Managed Health Care (DMHC) recently finalized regulations that require HMO patients to be seen in a timely manner. The primary intent of these regulations and the underlying legislation is to require HMOs to ensure that their networks of providers have the capacity and availability to provide care to enrollees within certain time-frames for various levels of care.

CMA supported the underlying legislation, AB 2179, which was signed into law in 2002 and directed the state to develop regulations to ensure that HMO enrollees have timely access to health care services. CMA supported that legislation because it promised to improve the adequacy of provider networks.

Both the regulations and underlying law impose requirements on HMOs, not physicians. However, to comply with the regulations, HMOs will very likely pass on these requirements contractually to physicians and other providers. This, in turn, may require modification of existing physician office procedures to comply with the additional scheduling or reporting requirements.

In most cases, under the new regulations, HMO doctors will be required to see a patient for a primary care appointment within 10 business days. Specialists will be required to see patients within two weeks. Those with urgent problems requiring prompt attention should be seen within 48 hours.

HMOs still need to develop the contractual amendments necessary to comply with these regulations, so there will not be a full picture of what physicians need to know regarding contracting or implementation for some time. HMOs have until October 17, 2010 to file a compliance plan with DMHC, at which point CMA should have a more fully developed picture of what physicians need to know and do. CMA has worked with and will continue to work with DMHC through this process.

CMA has scheduled two webinars on this topic with Armand Feliciano, CMA Associate Director of Medical and Regulatory Policy. The first is Thursday, January 28 from 12:15 – 1:15 p.m., and the second on Wednesday, February 3 from 12:15 – 1:15 p.m. Registration is free to members; to register go to <http://www.cmanet.org/calendar>.

Sources: CMA Alert Issue No. 2175; San Jose Mercury News

Guide for Medicare Consultation Billing Available

CMA has updated its 2010 Guide for Medicare Consultation Code Reporting to provide additional clarity on this understandably confusing and complex issue. Please discard any previous version that you may have downloaded, and download the updated version at <http://www.cmanet.org>. You will need a username and password to obtain access to the consultation guide on the CMA website. In order to register, you will need the physician's CA license and CMA ID number. If you do not have access to the CMA member-secure website, you may request a copy of the guide by contacting sandie@sccma.org.