Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services

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CHANGE REQUEST 1756

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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Appendix A	A1 - A2 (2 pp.)	A1 - A2 (2 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: July 1, 2001
IMPLEMENTATION DATE: September 27, 2001

Claims previously adjudicated are unaffected.

Section 2070 - 2070.1, Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests, is revised to manualize Program Memorandum B-01-28 (released on April 19, 2001) regarding physician supervision of diagnostic tests, with the following corrections:

Physical therapists who do not possess the ABPTS (American Board of Physical Therapy Specialties) certification by July 1, 2001, may continue to furnish those diagnostic tests that require the certification if they have been furnishing such diagnostic tests prior to May 1, 2001.

The following codes are assigned the supervision levels set forth below:

76506 - 1	76519 - 1	76815 - 1
76511 - 2	76529 - 1	76825 - 1
76512 - 2	76800 - 1	76885 - 1
76513 - 2	76805 - 1	95070 - 2
76516 - 1	76810 - 1	95071 - 2

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CMS-Pub. 14-3

Section 2070.5, Coverage of Independent Physiological Laboratory Services, is **deleted** due to obsolete policy.

Section 5217, Reasonable Charges Involving Exclusion of Refractive Services, is **deleted** due to obsolete policy.

Section 15006, Method for Computing Fee Schedule Amounts, reflects the conversion factor for year 2001, and the methods for computing payment amounts for 2001 through 2002.

Section 15021, Ordering Diagnostic Tests, is being added to clarify 42 CFR 410.32(a), which requires that all diagnostic tests be ordered by the treating practitioner.

Section 15039, Optometry Services, provides that refractions are a non-covered service.

Section 15044, Assistant at Surgery Services, is revised to clarify the services which may be billed for assistant at surgery services. Modifiers AK, AL, AN, AU, AV, and AW were discontinued December 31, 1998 and are deleted.

Section 15049, Ocular Photodynamic Therapy (OPT), is being added to reflect the use of CPT code 67221 to bill for this service.

Section 15050, Allergy Testing and Immunotherapy, clarifies Medicare policy regarding payment for doses of antigen.

Section 15360, Echocardiography Services (Codes 93303 - 93350, is revised to reflect the deletion of Q0188 effective 12/31/00 and replaced with A9700 effective 1/1/2001.

Section 15068M., Correct Coding Policy, is added to clarify when a component code is reported as services associated with services described by the comprehensive code, to report the former code represents a misuse in this code and should not be separately allowed.

Section 15068N., Use of Modifiers, to include eight new modifiers and a change in the -GB modifier to -59.

Section 15501, Evaluation and Management Services Codes - General (Codes 99201 - 99499), is revised to clarify when it is appropriate for specific non-physician practitioners to provide physician services, such as evaluation and management services. The revision also states that all provided services must be medically necessary for Medicare payment purposes.

Section 15501B., Selection of Level of Evaluation and Management Service, is revised to clarify that the physician or any non-physician practitioner with the ability to bill Medicare services must submit his/her bill to reflect the actual service or individual portion of a service performed.

Section 15502, Payment for Office/Outpatient Visits (Codes 99201 - 99215), is revised to clarify the definition of a new patient for selection of a visit code by inserting the term “face to face”.

Section 15506, Consultations Requested by Members of Same Group, is revised to clarify that non-physician practitioners may also perform consultations as well as requesting consultations when it is medically necessary and the service is within the scope of practice for the limited licensed practitioners in the State in which they practice.

Section 15510, Home Care and Domiciliary Care Visits (Codes 99321 - 99353), is clarified to identify the correct POS code when Part A SNF benefits apply.

Section 15511.1, Prolonged Services (Codes 99354 - 99355), is revised to include the Home Services visit codes to be used as companion codes for code 99354.

Appendix A, provides updated Geographic Practice Cost Indices.

CLARIFICATION--EFFECTIVE DATE: Not applicable
IMPLEMENTATION DATE: October 1, 2001

Section 15047, Postoperative Services Paid Under the Physician Fee Schedule, this instruction provides further clarification to payment policy for preoperative evaluations obtained outside of the global surgical period, and establishes a clear hierarchy for denying such services.

Services identified with ICD-9 CODE V72.81 through V72.84 are not considered routine services and may not be denied, by carriers, as routine services. However, these ICD-9 codes do not, in and of themselves, establish medical necessity, therefore claims containing these codes may be subject to medical necessity determinations as described in §15047H.

CHAPTER II
COVERAGE AND LIMITATIONS

Covered Medical and Other Health Services

CHAPTER II

4. Parasomnia.--Parasomnias are a group of conditions that represent undesirable or unpleasant occurrences during sleep. Behavior during these times can often lead to damage to the surroundings and injury to the patient or to others. Parasomnia may include conditions such as sleepwalking, sleep terrors, and REM sleep behavior disorders. In many of these cases, the nature of these conditions may be established by careful clinical evaluation. Suspected seizure disorders as possible cause of the parasomnia are appropriately evaluated by standard or prolonged sleep EEG studies. In cases where seizure disorders have been ruled out and in cases that present a history of repeated violent or injurious episodes during sleep, polysomnography may be useful in providing a diagnostic classification or prognosis. Use HCPCS procedure codes 95828 and/or 95822.

C. Polysomnography for Chronic Insomnia Is Not Covered.--Evidence at the present time is not convincing that polysomnography in a sleep disorder clinic for chronic insomnia provides definitive diagnostic data or that such information is useful in patient treatment or is associated with improved clinical outcome. The use of polysomnography for diagnosis of patients with chronic insomnia is not covered under Medicare because it is not reasonable and necessary under §1862(a)(1)(A) of the Act.

D. Coverage of Therapeutic Services.--Sleep disorder clinics may at times render therapeutic as well as diagnostic services. Therapeutic services may be covered in a hospital outpatient setting or in a freestanding facility provided they meet the pertinent requirements for the particular type of services and are reasonable and necessary for the patient, and are performed under the direct personal supervision of a physician.

2070. DIAGNOSTIC X-RAY, DIAGNOSTIC LABORATORY, AND OTHER DIAGNOSTIC TESTS

This section sets forth the levels of physician supervision required for furnishing the technical component of diagnostic tests for a Medicare beneficiary who is not a hospital inpatient or outpatient. Section 410.32(b) of the Code of Federal Regulations, as adopted in the Medicare physician fee schedule Final Rule of October 31, 1997, requires that "diagnostic tests covered under §1861(s)(3) of the Social Security Act (the Act) and payable under the physician fee schedule, with certain exceptions listed in the regulation, have to be performed under the supervision of an individual meeting the definition of a physician" (§1861(r) of the Act) to be considered reasonable and necessary and, therefore, covered under Medicare. The regulation defines these levels of physician supervision for diagnostic tests as follows:

General supervision--means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Direct supervision--in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

Personal supervision--means a physician must be in attendance in the room during the performance of the procedure.

One of the following numerical levels is assigned to each CPT or HCPCS code in the Medicare Physician Fee Schedule Database:

0 = Procedure is not a diagnostic test or procedure is a diagnostic test which is not subject to the physician supervision policy.

1 = Procedure must be performed under the general supervision of a physician.

2 = Procedure must be performed under the direct supervision of a physician.

3 = Procedure must be performed under the personal supervision of a physician.

4 =Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.

5 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.

6 = Procedure must be performed by a physician or by a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law.

66 = Procedure must be performed by a physician or by a PT with ABPTS certification and certification in this specific procedure.

77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.

6a = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT but only the PT with ABPTS certification may bill.

7a = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT but only the PT with ABPTS certification may bill.

22 = Procedure may be performed by a technician with on-line real-time contact with physician.

21 = Procedure must be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.

Nurse practitioners, clinical nurse specialists, and physician assistants are not defined as physicians under §1861(r) of the Act. Therefore, they may not function as supervisory physicians under the diagnostic tests benefit (§1861(s)(3) of the Act). However, when performing diagnostic tests under their own statutory benefits (§181(s)(2)(K) of the Act), they do not need to comply with §2070 of the Medical Carriers Manual (the manual). Instead, they may perform diagnostic tests pursuant to State scope of practice laws and under the applicable State requirements for physician supervision or collaboration.

Because the diagnostic tests benefit set forth in §1861(s)(3) of the Act is separate and distinct from the incident to benefit set forth in §1861(s)(2) of the Act, diagnostic tests need not meet the incident to requirements of §2050 of the manual. Diagnostic tests may be furnished under situations that meet the incident to requirements. However, the carriers must not scrutinize claims for diagnostic tests utilizing the incident to requirements.

C. Scope of Portable X-Ray Benefit.--In order to avoid payment for services which are inadequate or hazardous to the patient, the scope of the covered portable x-ray benefit is defined as:

- o Skeletal films involving arms and legs, pelvis, vertebral column, and skull;
- o Chest films which do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examinations); and
- o Abdominal films which do not involve the use of contrast media.

D. Exclusions From Coverage as Portable X-Ray Services.--Procedures and examinations which are not covered under the portable x-ray provision include the following:

- o Procedures involving fluoroscopy;
- o Procedures involving the use of contrast media;
- o procedures requiring the administration of a substance to the patient or injection of a substance into the patient and/or special manipulation of the patient;
- o Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require that medical judgment be exercised;
- o Procedures requiring special technical competency and/or special equipment or materials;
- o Routine screening procedures; and
- o Procedures which are not of a diagnostic nature.

E. Reimbursement Procedure.--

1. Name of Ordering Physician.--Assure that portable x-ray tests have been provided on the written order of a physician. Accordingly, if a bill does not include the name of the physician who ordered the service, that information must be obtained before payment may be made.

2. Reason Chest X-Ray Ordered.--Because all routine screening procedures and tests in connection with routine physical examinations are excluded from coverage under Medicare, all bills for portable x-ray services involving the chest contain, in addition to the name of the physician who ordered the service, the reason an x-ray test was required. If this information is not shown, it is obtained from either the supplier or the physician. If the test was for an excluded routine service, no payment may be made.

See also §§4110 ff. for additional instructions on reviewing bills involving portable -ray.

F. Electrocardiograms.--The taking of an electrocardiogram tracing by an approved supplier of portable x-ray services may be covered as an "other diagnostic test." The health and safety standards referred to in §2070.4B are thus also applicable to such diagnostic EKG services, e.g., the technician must meet the personnel qualification requirements in the Conditions for Coverage of Portable x-ray Services. (See §50-15 (Electrocardiographic Services) in the Coverage Issues Manual.)

2075. X-RAY, RADIUM, AND RADIOACTIVE ISOTOPE THERAPY

These services also include materials and services of technicians.

X-ray, radium, and radioactive isotope therapy furnished in a nonprovider facility require direct personal supervision of a physician. The physician need not be in the same room, but must be in the area and immediately available to provide assistance and direction throughout the time the procedure is being performed. This level of physician involvement does not represent a physician's service and cannot be billed as a Part B service. The physician would have to furnish a reasonable and necessary professional service as defined in §§2020A, 8304.1 and 8314.1 in order for the service to be covered.

However, effective for radiation therapy services furnished on or after April 1, 1989, radiologists' weekly treatment management services are payable as set forth in §5262.K.

A separate charge for the services of a physicist is not recognized unless such services are covered under the "incident to" provision (§2050ff) or the services are included as part of a technical component service billed by a freestanding radiation therapy center. The incident to provision may also be extended to include all necessary and appropriate services supplied by a radiation physicist assisting a radiologist when the physicist is in the physician's employ and working under direct supervision. Accordingly, to make sure that the additional charge made by the radiologist for the physicist's service is reasonable, the carrier must, as is done for paraprofessionals, set up either a reasonable charge screen for the physician's services to include consideration of the additional charge or a screen just for the technical service component. However, for the services of a physicist furnished on or after April 1, 1989, see §5262K.

Section

Special Situations and Instructions

Section

l. The ambulance company makes a separate charge to all patients, both Medicare and non-Medicare, for unusual waiting time.

2. It is the general practice of ambulance companies in the locality to make an extra charge for unusual waiting time.

3. The claim is completely documented as to why the ambulance was required to wait and the exact time involved. The ambulance company should ordinarily obtain this documentation from the physician or hospital personnel responsible for admitting or discharging patients.

However, if this is not possible, the documentation may be a statement from the ambulance company based on a record containing all pertinent facts necessary to support the claim. The ambulance company could establish the necessary record by instructing its crews to ascertain from the physician or responsible hospital personnel the reason for the wait at the time it occurs. The reason could be entered on the ambulance log over the signature of the physician or other informant.

5215.2 Apportionment of Payment for Ambulance Services.--Partial payments for ambulance services determined in accordance with §2125(5) should be apportioned among the suppliers where (l) more than one supplier has furnished the covered ambulance service; and (2) one or more such suppliers has accepted an assignment of the Medicare benefit. In such cases, the shares allocable to the respective suppliers for their services should be paid to those suppliers which have accepted assignments and the balance of the partial payment (if any) should be paid to the beneficiary. Where there is no assignment no apportionment by the carrier is necessary, since all of the partial payment is made to the beneficiary.

Where apportioning a partial payment (i.e., 80% of the reasonable charge that can be allowed after the deductible has been met) is necessary, the carrier should use the ratios of (l) the full reasonable charges that would have been applicable to the covered services of each supplier, had full (rather than partial) payment been involved, to (2) the total of such reasonable charges. For example, where a partial payment of $l00 can be made for the covered services that three ambulance companies have rendered, and the full reasonable charges for each company's covered services would have been $150, $75, and $75 respectively; then the first ambulance company would be paid $50 (i.e., one half of the partial payment), and the two other companies would each be paid $25 (i.e., one quarter of the partial payment).

The use of the ratios outlined above may entail some claims processing complexities. For example, one (or more) of the ambulance companies involved in a partial payment situation may not be located in the service area of the carrier with claims processing jurisdiction (see §3100).

In such instances, it will be necessary for the carrier processing the claim to obtain customary and prevailing charge data, (with regional office assistance), from the carrier in whose service area the ambulance company is located.

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CHAPTER XV
FEE SCHEDULE FOR PHYSICIANS' SERVICES

Section

Section

15000. SCHEDULE FOR PHYSICIANS' SERVICES

Pay for physicians' services furnished on or after January 1, 1992 on the basis of a fee schedule. The Medicare allowed charge for such physicians' services is the lower of the actual charge or the fee schedule amount. The Medicare payment is 80 percent of the allowed charge after the deductible is met.

15002. PHYSICIANS' SERVICES PAID UNDER FEE SCHEDULE

Use the fee schedule when paying for the following physicians' services, if those services were payable on a reasonable charge or fee schedule basis prior to January 1, 1992.

- Professional services (including attending physicians' services furnished in teaching settings) of doctors of medicine and osteopathy (including osteopathic practitioners), doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, and chiropractors;

- Supplies and services covered incident to physicians' services other than certain drugs covered as incident to services;

- Physical and occupational therapy furnished by physical therapists and occupational therapists in independent practices;

- Diagnostic tests other than clinical laboratory tests. See §5114 for payment for clinical diagnostic laboratory tests;

- Radiology services; and

- Monthly capitation payment (MCP) for physicians' services associated with the continuing medical management of end stage renal disease (ESRD) services.

Prior to January 1, 1992, do not use the fee schedule as the basis for payment for physicians' outpatient services for occupational and physical therapy services rendered by providers such as hospitals, SNFs, CORFs, HHAs, etc. The pre-January 1, 1992 payment method for these services was neither fee schedule nor reasonable charge. Therefore, the payment method (i.e., the reasonable costs for outpatient PT and OT rendered by providers) is not replaced by the fee schedule. Also, do not use the fee schedule to pay for direct medical and surgical services of teaching physicians in hospitals that have elected cost payment under §1861(b)(7) of the Act. Note also that the administration or injection of pneumococcal, influenza, or hepatitis B vaccines is not paid for under the physician fee schedule. Continue to pay for these injection services under section 5202.

When processing a claim, continue to determine if a service is reasonable and necessary to treat illness or injury. If a service is not reasonable and necessary to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), consider the service to be noncovered notwithstanding the presence of a payment amount for the service in the Medicare fee schedule. The presence of a payment amount in the Medicare physician fee schedule and the Medicare physician fee schedule data base (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare. The nature of the status indicator in the database does not control coverage except where the status is N for noncovered.

15004. ENTITIES/SUPPLIERS WHOSE PHYSICIANS' SERVICES ARE PAID FOR UNDER FEE SCHEDULE

As appropriate, pay for the above listed physicians' services under the fee schedule when they are billed by:

- A physician or physician group including optometrists, dentists, oral and maxillofacial surgeons, podiatrists, and chiropractors,

- A privately practicing physical therapist, including a speech-language pathologist (for outpatient physical therapy and speech-language services),

- A privately practicing occupational therapist (for outpatient occupational therapy services),

- A non-physician practitioner including a nurse practitioner, a physician assistant and a clinical nurse specialist beginning January 1, 1998, with respect to services these practitioners are authorized to furnish under state law.

- Another entity that furnishes outpatient physical therapy, occupational therapy, and speech-language pathology services: namely, a rehabilitation agency, a public health agency, a clinic, a skilled nursing facility, a home health agency (for beneficiaries who are not eligible for home health benefits because they are not home bound beneficiaries entitled to home health benefits), hospitals (when such services are provided to an outpatient or to a hospital inpatient who is entitled to benefits under Part A but who has exhausted benefits during a spell of illness, or who is not entitled to Part A benefits) and comprehensive outpatient rehabilitation facilities (CORFs). The fee schedule also applies to outpatient rehabilitation services furnished under an arrangement with any of the enumerated entities that are to be paid on the basis of the physician fee schedule.

- The supplier of the technical component of any radiology or diagnostic service, or

- An independent laboratory doing anatomic pathology services.

Also, pay for the above listed physicians' services under the fee schedule when they are billed by entities authorized to bill for physicians, suppliers, etc. under the reassignment rules. See §3060ff.

15006. METHOD FOR COMPUTING FEE SCHEDULE AMOUNT

A. Formula.--Compute the fully implemented resource-based Medicare fee schedule amount for a given service by using the following formula:

Fee Schedule Amount = [(RVUw x GPCIw) + (RVUpe x GPCIpe) + (RVUm x GPCIm)] x CF

For each fee schedule service, there are three relative values:

- A relative value for physician work (RVUw),
- A relative value for practice expense (RVUpe), and
- A relative value for malpractice (RVUm).

For each payment locality, there are three geographic practice cost indices (GPCIs):

- A GPCI for physician work (GPCIw),
- A GPCI for practice expense (GPCIpe), and
- A GPCI for malpractice (GPCIm).

Use the applicable national conversion factor (CF) in the computation of every fee schedule amount. The national CFs are:

2001	$38.2581	2000	$36.6137	1999	$34.7315	1998	$36.6873

1997	$40.9603(S) $33.8454(NS) $35.7671(PC)	1996	$40.7986(S) $34.6293(NS) $35.4173(PC)	1995	$39.447(S) $34.616(NS) $36.382(PC)	1994	$35.158(S) $32.905(NS) $33.718(PC)

1993	$31.962(S) $31.249(NS)	1992	$31.001

S= Surgical NS= Nonsurgical PC= Primary Care

For the years 1999 through 2002, payment attributable to practice expenses will transition from charge-based amounts to resource-based practice expense RVUs. The practice expense RVUs calculated by CMS (formerly HCFA) reflect the following transition formula:

1999 - 75 percent of charged-based RVUs and 25 percent of the resource-based RVUs.

2000 - 50 percent of the charge-base RVUs and 50 percent of the resource-based RVUs.

2001 - 25 percent of the charge-based RVUs and 75 percent of the resource-based RVUs.

2002 - 100 percent of the resource-based RVUs.

CMS has calculated separate facility and non-facility resource-based practice expense RVUs. In addition, some services were subject to a reduction in payment in facility settings under the charge-based system. For these services, the transitioned facility practice expense RVUs will reflect the reduced charge-based RVUs and the facility resource based RVUs. The transitioned non-facility RVUs will reflect the unreduced charge-based RVUs and the resource-based non-facility RVU. For all other services, the facility or non-facility transitioned RVUs will reflect the base RVUs and the respective facility or non-facility resource-based RVUs.

Example of Computation of Fee Schedule Amount

To compute the payment amount for biopsy of skin lesion (CPT code 11100) in Birmingham, Alabama in 1996, use the following RVUs for work, practice expense, and malpractice:

Work RVU (RVUw) = 0.81
Practice expense RVU (RVUpe) = 0.51
Malpractice RVU (RVUm) = 0.04

Next, use the GPCI values for work, practice expense, and malpractice for Birmingham:

Work GPCI (GPCIw) = 0.994
Practice expense GPCI (GPCIpe) = 0.912
Malpractice GPCI (GPCIm) = 0.927

Finally, using $40.7986 as the uniform national CF, place the values into the formula provided and compute:

Payment = (RVUw x GPCIw) + (RVUpe x GPCIpe) + (RVUm x GPCIm) x CF
Payment = (0.81 x 0.994) + (0.51 x 0.912) + (0.04 x .927) x 40.7986
Payment = (0.81) + (0.47) + (0.04) x 40.7986
Payment = (1.32) x 40.7986
Payment = $53.85 (Full Fee Schedule Payment)

Round fee schedule amounts to the nearest cent.

CMS is providing you the essential components of the fee schedule, including the calculation of the fee schedule payment amounts for each locality, via the Medicare Fee Schedule Data Base.

B. No CMS RVUs.--The only services for which CMS does not give you relatives values are:

- Those with local codes,
- Those with national codes where national relative values have not been established,
- Those requiring "By Report" payment or carrier pricing, and
- Those which are not included in the definition of physicians' services.

For services with national codes but for which national relative values have not been provided, establish local relative values (to be multiplied, in your system, by the national CF), as appropriate, or establish a flat local payment amount, whichever you prefer.

The "By Report" services (with national codes or modifiers) include services with codes ending in 99, team surgery services, unusual services, reduced services, and radio nuclide codes A4641 and 79900. The status indicators of the Medicare Fee Schedule Data Base identify these specific national codes and modifiers that you are to continue to pay for on a "By Report" basis. Do not establish RVUs for them. Similarly, do not establish RVUs for "By Report" services with local codes or modifiers.

Do not establish RVUs for noncovered and always bundled services for which CMS has not established national RVUs. The Medicare fee schedule data base identifies noncovered national codes and codes which are always bundled.

C. Diagnostic Procedures and Other Codes With Professional and Technical Components.--For diagnostic procedure codes and other codes describing services with both professional and technical components, relative values are provided for the global service, the professional component, and the technical component. The determination of which HCPCS codes fall into this category is made by CMS.

D. No Special RVUs for Limited License Practitioners.--There are no special RVUs for limited license physicians, e.g., optometrists, podiatrists. The fee schedule RVUs apply to a service regardless of whether a medical doctor, doctor of osteopathy, or limited license physician performs the service.

If a physician bills a visit on the same day that he or she also bills for physical therapy using CPT physical therapist codes, the physician must be prepared to document that the visit was unrelated to the physical therapy services for which separate payment is made.

Physicians and independently practicing physical therapists may bill for physical therapy modalities and therapies using the CPT codes (97010-97799). Do not restrict their use of these codes other than to ensure that duplicate payment is not made for services on the same date of service. For example, you may not restrict either physicians or independently practicing physical therapists to use of the alpha-numeric codes. Pay the same amount for a code regardless of whether an independently practicing physical therapist or a physician bills it.

15008. TRANSITION PAYMENTS

The fee schedule amounts computed above apply in 1996 if there is no transition to the fee schedule for that particular code in that area. The transition occurred from 1992 through 1995. To determine whether the transition provisions apply, the historical payment basis for a service is compared to the fee schedule amount computed under §15006. The results are transition fee schedule amounts applicable in 1992 through 1995.

15010. BUNDLED SERVICES/SUPPLIES

There are a number of services/supplies which are covered under Medicare and which have CPT codes, but they are services for which Medicare bundles payment into the payment for other related services.

A. Routinely Bundled.--These are services/supplies for which separate payment is almost never made. CMS has provided RVUs for many of the bundled services/supplies. However, the RVUs are not for Medicare payment use. Do not establish your own relative values for these services.

If you receive a claim which is solely for one of these always bundled services or supplies, develop the claim. If the physician has, at any time in the past year, rendered another service to the beneficiary, consider the bill for the service/supply part of or incident to that prior service. If the physician has not provided another service to the patient during that time period, use RVUs, if provided, as a guide for payment, for any service which is the subject of the claim on a "By Report" basis if it qualifies as a covered physician service. However, deny payment for any service/supply item which is the sole subject of the claim, since there is no service to which it can be incident.

B. Injection Services.--Injection services (codes 90782, 90783, 90784, 90788, and 90799) included in the fee schedule are not paid for separately if the physician is paid for any other physician fee schedule service rendered at the same time. Pay separately for those injection services only if

87164 Dark field examination, any source (e.g. penile, vaginal, oral, skin); includes specimen collection
87207 Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g. malaria, kala azar, herpes)
88371 Protein analysis of tissue by Western Blot, with interpretation and report.
88372 Protein analysis of tissue by Western Blot, immunological probe for band identification, each
89060 Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)

15021. ORDERING DIAGNOSTIC TESTS

A. Definitions.--

1. A "diagnostic test" includes all diagnostic x-ray tests, all diagnostic laboratory tests, and other diagnostic tests furnished to a beneficiary.

2. A "treating physician" is a physician, as defined in §1861(r) of the Social Security Act (the Act), who furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results of a diagnostic test in the management of the beneficiary's specific medical problem.

NOTE: A radiologist performing a therapeutic interventional procedure is considered a treating physician. A radiologist performing a diagnostic interventional or diagnostic procedure is not considered a treating physician.

3. A "treating practitioner" is a nurse practitioner, clinical nurse specialist, or physician assistant, as defined in §1861(s)(2)(K) of the Act, who furnishes, pursuant to State law, a consultation or treats a beneficiary for a specific medical problem, and who uses the result of a diagnostic test in the management of the beneficiary's specific medical problem.

4. A "testing facility" is a Medicare provider or supplier that furnishes diagnostic tests. A testing facility may include a physician or a group of physicians (e.g., radiologist, pathologist), a laboratory, or an independent diagnostic testing facility (IDTF).

5. An "order" is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (e.g., if test X is negative, then perform test Y). An order may include the following forms of communication:

a. A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility;

b. A telephone call by the treating physician/practitioner or his/her office to the testing facility; and

c. An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

NOTE: If the order is communicated via telephone, both the treating physician/practitioner or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

B. Treating Physician/Practitioner Ordering of Diagnostic Tests.--The treating

physician/practitioner must order all diagnostic tests furnished to a beneficiary who is not an institutional inpatient or outpatient. A testing facility that furnishes a diagnostic test ordered by the treating physician/practitioner may not change the diagnostic test or perform an additional diagnostic test without a new order. This policy is intended to prevent the practice of some testing facilities to routinely apply protocols which require performance of sequential tests.

C. Different Radiology Diagnostic Test.--When the radiologist at a testing facility determines that an ordered diagnostic radiology test is clinically inappropriate or suboptimal, and that a different diagnostic test should be performed (e.g., an MRI should be performed instead of a CT scan because of the clinical indication), the radiologist/testing facility may not perform the unordered test until a new order from the treating physician/practitioner has been received. Similarly, if the result of an ordered diagnostic test is normal and the radiologist believes that another diagnostic test should be performed (e.g., a renal sonogram was normal and based on the clinical indication, the radiologist believes an MRI will reveal the diagnosis), an order from the treating physician must be received prior to performing the unordered diagnostic test.

D. Additional Diagnostic Radiology Test Exception.--If the testing facility cannot reach the treating physician/practitioner to change the order or obtain a new order and documents this in the medical record, then the testing facility may furnish the additional diagnostic test if all of the following criteria apply:

1. The testing center performs the diagnostic test ordered by the treating physician/practitioner;

2. The radiologist at the testing facility determines and documents that, because of the abnormal result of the diagnostic test performed, an additional diagnostic test is medically necessary;

3. Delaying the performance of the additional diagnostic test would have an adverse effect on the care of the beneficiary;

4. The result of the test is communicated to and is used by the treating physician/practitioner in the treatment of the beneficiary; and

5. The radiologist at the testing facility documents in his/her report why additional testing was done.

EXAMPLE: (a) the last cut of an abdominal CT scan with contrast shows a mass requiring a pelvic CT scan to further delineate the mass; (b) a bone scan reveals a lesion on the femur requiring plain films to make a diagnosis.

E. Radiologist Exception.--This exception applies to a radiologist of a testing facility who furnishes a diagnostic test to a beneficiary who is not a hospital inpatient or outpatient. The radiologist must document accordingly in his/her report to the treating physician/practitioner.

1. Test Design.--Unless specified in the order, the radiologist may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).

2. Clear Error.--The radiologist may modify, without notifying the treating physician/practitioner, an order with clear and obvious errors that would be apparent to a reasonable layperson, such as the patient receiving the test (e.g., x-ray of wrong foot ordered).

3. Patient Condition.--The radiologist may cancel, without notifying the treating physician/practitioner, an order because the beneficiary's physical condition at the time of diagnostic testing will not permit performance of the test (e.g., a barium enema cannot be performed because of residual stool in colon on scout KUB; PA/LAT of the chest cannot be performed because the patient is unable to stand). When an ordered diagnostic test is cancelled, any medically necessary preliminary or scout testing performed is payable.

F. Surgical/Cytopathology Exception.--This exception applies to an independent laboratory's pathologist or a hospital pathologist who furnishes a pathology service to a beneficiary who is not a hospital inpatient or outpatient, and where the treating physician/practitioner does not specifically request additional tests the pathologist may need to perform. When a surgical or cytopathology specimen is sent to the pathology laboratory, it typically comes in a labeled container with a requisition form that reveals the patient demographics, the name of the physician/practitioner, and a clinical impression and/or brief history. There is no specific order from the surgeon or the treating physician/practitioner for a certain type of pathology service. While the pathologist will generally perform some type of examination or interpretation on the cells or tissue, there may be additional tests, such as special stains, that the pathologist may need to perform, even though they have not been specifically requested by the treating physician/practitioner. The pathologist may perform such additional tests under the following circumstances:

1. These services are medically necessary so that a complete and accurate diagnosis can be reported to the treating physician/practitioner;

2. The results of the tests are communicated to and are used by the treating physician/practitioner in the treatment of the beneficiary; and

3. The pathologist documents in his/her report why additional testing was done.

EXAMPLE: A lung biopsy is sent by the surgeon to the pathology department, and the pathologist finds a granuloma which is suspicious for tuberculosis. The pathologist cultures the granuloma, sends it to bacteriology, and requests smears for acid fast bacilli (tuberculosis). The pathologist is expected to determine the need for these studies so that the surgical pathology examination and interpretation can be completed and the definitive diagnosis reported to the treating physician for use in treating the beneficiary.

15022. PAYMENT CONDITIONS FOR RADIOLOGY SERVICES

A. Professional Component (PC).--Pay for the PC of radiology services furnished by a physician to an individual patient in all settings under the fee schedule for physician services regardless of the specialty of the physician who performs the service. For services furnished to hospital patients, pay only if the services meet the conditions for fee schedule payment in §15014.C.1 and are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as an interpretation of diagnostic procedures and the PC of therapeutic procedures. The interpretation of a diagnostic procedure includes a written report.

B. Technical Component (TC).--

1. Hospital Patients.--Do not pay for the TC of radiology services furnished to hospital patients. Payment for physicians' radiological services to the hospital, e.g., administrative or supervisory services, and for provider services needed to produce the radiology service is made by the intermediary as provider services through various payment mechanisms.

2. Services Not Furnished in Hospitals.--Pay under the fee schedule for the TC of radiology services furnished to beneficiaries who are not patients of any hospital in a physician's office, a freestanding imaging or radiation oncology center, or other setting that is not part of a hospital.

3. Services Furnished in Leased Departments.--In the case of procedures furnished in a leased hospital radiology department to a beneficiary who is neither an inpatient nor an outpatient of any hospital, e.g., the patient is referred by an outside physician and is not registered as a hospital outpatient, both the PC and the TC of the services are payable under the fee schedule.

4. Purchased TC Services.--Apply the purchased services limitation as set forth in §15048 to the TC of radiologic services other than screening mammography procedures.

5. Computerized Axial Tomography (CT) Procedures.--Do not reduce or deny payment for medically necessary multiple CT scans of different areas of the body that are performed on the same day.

The TC RVUs for CT procedures that specify "with contrast" include payment for high osmolar contrast media. When separate payment is made for low osmolar contrast media under the conditions set forth in subsection F.1, reduce payment for the contrast media as set forth in subsection F.2.

6. Magnetic Resonance Imaging (MRI) Procedures.--Do not make additional payments for 3 or more MRI sequences. The RVUs reflect payment levels for 2 sequences.

The TC RVUs for MRI procedures that specify "with contrast" include payment for paramagnetic contrast media. Do not make separate payment under code A4647.

A diagnostic technique has been developed under which an MRI of the brain or spine is first performed without contrast material, then another MRI is performed with a standard (0.1mmol/kg) dose of contrast material and, based on the need to achieve a better image, a third MRI is performed with an additional double dosage (0.2mmol/kg) of contrast material. When the high-dose contrast technique is utilized:

- Do not pay separately for the contrast material used in the second MRI procedure;

- Pay for the contrast material given for the third MRI procedure through supply code A4643 when billed with CPT codes 70553, 72156, 72157, and 72158;

- Do not pay for the third MRI procedure. For example, in the case of an MRI of the brain, if CPT code 70553 (without contrast material, followed by with contrast material(s) and further sequences) is billed, make no payment for CPT code 70551 (without contrast material(s)), the additional procedure given for the purpose of administering the double dosage, furnished during the same session. Medicare does not pay for the third procedure (as distinguished from the contrast material) because the CPT definition of code 70553 includes all further sequences; and

- Do not apply the payment criteria for low osmolar contrast media in subsection F to billings for code A4643.

7. Stressing Agent.--Make separate payment under code J1245 for pharmacologic stressing agents used in connection with nuclear medicine and cardiovascular stress testing procedures furnished to beneficiaries in settings in which TCs are payable. Such an agent is classified as a supply and covered as an integral part of the diagnostic test. However, pay for code J1245 under the policy for determining payments for "incident to" drugs.

C. Nuclear Medicine (CPT 78000 Through 79999).--

1. Payments for Radionuclides.--The TC RVUs for nuclear medicine procedures (CPT codes 78XXX for diagnostic nuclear medicine, and codes 79XXX for therapeutic nuclear medicine) do not include the radionuclide used in connection with the procedure. These substances are separately billed under codes A4641 and A4642 for diagnostic procedures and code 79900 for therapeutic procedures and are paid on a "By Report" basis depending on the substance used. In addition, CPT code 79900 is separately payable in connection with certain clinical brachytherapy procedures. (See subsection D.3.)

2. Application of Multiple Procedure Policy (CPT Modifier 51).--Apply the multiple procedure reduction as set forth in §15038 to the following nuclear medicine diagnostic procedures: codes 78306, 78320, 78802, 78803, 78806, and 78807.

3. Generation and Interpretation of Automated Data.--Payment for CPT codes 78890 and 78891 is bundled into payments for the primary procedure.

15036. SITE-OF-SERVICE PAYMENT DIFFERENTIAL

Under the physician fee schedule, separate practice expense relative value units (PERVUs) are calculated for procedures furnished in facility and in non-facility settings. Facility PERVUs are applicable to procedures (except for therapy procedures) furnished:

- In hospitals;
- To patients in a Part A stay in a skilled nursing facility (SNF) identified on the HCFA 1500 claim form indicating Place of Service (POS) code 31; and
- In an ambulatory surgical center (ASC) that are included on the ASC approved list of procedures.

Non-facility PERVUs are applicable to procedures furnished:

- To patients who are not in a Part A stay in a SNF identified on the HCFA 1500 claim form indicating place of service (POS) code 32;
- In an ASC that is not included on the ASC approved list of procedures; and
- In all other facilities.

Non-facility PERVUs are applicable to therapy procedures regardless of whether they are furnished in facility or non-facility settings.

15038. MULTIPLE SURGERIES (CPT MODIFIER 51)

A. General.--When more than one surgical service is performed on the same patient, by the same physician, and on the same day:

- The fee schedule amount for a second procedure is 50 percent of the fee schedule amount that would have been otherwise applicable for that procedure; and
- The fee schedule amount for the third through fifth procedures is 50 percent of the fee schedule amount that would have been otherwise applicable for that procedure. Prior to January 1, 1995, the third through fifth procedures were paid at 25 percent of the fee schedule amount. Surgical procedures beyond the fifth are priced "by report" based on documentation of the services furnished. (See §4826.C for systems requirements related to payment for multiple surgeries.)

Sequence the procedures from the one which has the highest regular fee schedule amount to the one with the lowest. In the case of interventional radiology procedures, see §15022.E.

B. Multiple Endoscopies.--For multiple endoscopic procedures, use the full value of the highest valued endoscopy plus the difference between the next highest and the base endoscopy. For example, in the course of performing a fiberoptic colonoscopy (code 45378), a physician performs a biopsy (code 45380) and removes a polyp (code 45385). Both codes 45380 and 45385 contain the values of the base endoscopy, code 45378. Use the actual value of code 45385 plus the difference between codes 45380 and 45378. The endoscopic base codes are listed in the MFSDB. (See §4826.C.12 for additional information.)

15039. OPTOMETRY SERVICES

Effective April 1, 1987, Medicare pays for services of an optometrist, acting within the scope of his or her license, if he or she furnishes services that would be covered as physicians' services when performed by a doctor of medicine or osteopathy. To be covered under Medicare, the services must be medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all other applicable coverage requirements. (See also §§2020.5 and 5250.)

Medicare does not cover refractions. Therefore, payment for refractions is not included in the fee schedule amount for ophthalmological procedures (e.g., CPT codes 92002, 92004, 92012 and 92014). Physicians may bill the beneficiary separately for refractions using CPT code 92015.

15040. BILATERAL SURGERY

15040.1 General.--Make the reductions discussed in this section to subsequent bilateral surgical procedures performed by the same physician on the same day. See §4827 for systems requirements related to payment for bilateral procedures.

15040.2 Bilateral Surgery Indicators.--**{**tc \l4 "15040.2 Bilateral Surgery Indicators.--**}**Use the bilateral surgery indicator in the fee schedule data base shown for each code which indicates whether the bilateral surgery reduction policy applies to the code.

A. Bilateral Surgery Indicator Equals 0.--The bilateral adjustment is inappropriate for codes with indicator 0 because of physiology or anatomy or because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

Base payment on the lower of (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single procedure if the procedure is reported with modifier -50 or is reported twice on the same day by any other method (e.g., with both RT and LT modifiers). This represents payment for the procedure performed on both sides of the body.

EXAMPLE: The fee schedule amount for code AAAAA is $125. The physician reports code AAAAA-LT and AAAAA-RT with an actual charge of $100 for each code. Base payment on the fee schedule amount for one code ($125) because it is lower than the actual charges for the procedure performed on both left and right sides ($200).

Some codes related to eyelids and/or eyelashes have a bilateral indicator of "0" but a multiple surgery indicator of "1" (standard or revised standard multiple surgery codes apply). (See §15038.) These codes may be provided as double bilaterals for which the physician bills as many units of the code as the number of procedures performed. For example, the physician bills for 4 units of the code if he or she performs the procedure on the top and bottom lid of each eye. You would then apply the multiple surgery rules in §15038 to the 4 units billed.

B. Bilateral Surgery Indicator Equals 1.--The bilateral adjustment is appropriate for codes with bilateral indicator of 1 because the code description is for a unilateral service and the payment amount is for a unilateral service, but physiology permits the service to be performed bilaterally.

Base payment on the lower of (a) the total actual charge for both sides or (b) 150 percent of the fee schedule payment for a single code if the code is billed with the bilateral modifier (CPT modifier -50) or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field).

EXAMPLE: The fee schedule amount for code BBBBB is $125. The physician reports code BBBBB-LT and BBBBB-RT with an actual charge of $100 for each code. Base payment on $187.50 (150 percent of the fee schedule amount for one code of $125) because it is lower than the actual charges for the left and right sides ($200). If the code is reported as a bilateral procedure and is reported with other procedure codes on the same date, apply the bilateral adjustment before applying any applicable multiple procedure rules.

C. Bilateral Surgery Indicator Equals 2.--The fee schedule amounts for these services were established as bilateral services because (a) the code description specifically states that the procedure is bilateral; (b) the code description states that the procedure may be performed either bilaterally or unilaterally; or 8 the procedure is typically performed as a bilateral procedure. Therefore, the bilateral adjustment does not apply.

Base payment on the lower of (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single procedure if the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field). This represents payment for the procedure performed on both sides of the body.

EXAMPLE: The fee schedule amount for code CCCCC is $125. The physician reports codes CCCCC-LT and CCCCC-RT with an actual charge of $100 for each code. Base payment on $125 because it is lower than the actual charges for the procedure done on both left and right sides ($200).

D. Bilateral Surgery Indicator Equals 3.--Base payment for each procedure on the lower of (a) the actual charge for both sides or (b) 100 percent of the fee schedule for each procedure if the code is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units column). The usual payment adjustment for bilateral procedures does not apply. Services in this category are generally radiology procedures or other diagnostic tests.

EXAMPLE: The fee schedule amount for code DDDDD is $125. The physician reports code DDDDD-LT and DDDDD-RT with an actual charge of $100 for each code. Base payment on $200 because it is the lower of the actual charge or the fee schedule amount ($250) for both procedures.

E. Bilateral Surgery Indicator Equals 9.--The concept does not apply. For example, visit codes cannot be bilateral.

15044. ASSISTANT AT SURGERY SERVICES

For assistant at surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the global surgery.

Do not pay assistants at surgery for surgical procedures in which a physician is used as an assistant at surgery in fewer than 5 percent of the cases for that procedure nationally. Use EOMB message 23.14 in §7012 to deny payment for the assistant at surgery services listed.

First, as the words denote, an assistant at surgery must actively assist when a physician performs a Medicare-covered surgical procedure. This necessarily entails that the assistant be involved in the actual performance of the procedure, not simply in other, ancillary services. Since an assistant would, thus, be occupied during the surgical procedure, the assistant would not be available to perform (and thus, could not bill for) another surgical procedure during the same time period.

In addition to the assistant at surgery modifiers 80, 81, or 82, any procedures submitted with modifiers AM, AS, AY, QB, or QU are subject to the assistant surgeon's policy enunciated in the Medicare physician fee schedule data base (MPFSDB). Accordingly, pay claims for procedures with these modifiers only if the services of an assistant surgeon are authorized.

Physicians are prohibited from billing a Medicare beneficiary for assistant at surgery services for procedure codes subject to the limit. Physicians who knowingly and willfully violate this prohibition and bill a beneficiary for an assistant at surgery service for these procedures codes may be subject to the penalties contained under §1842(j)(2) of the Act.

15046. CO-SURGEONS/SURGICAL TEAM

For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "By Report" basis.

15047. PREOPERATIVE SERVICES

A. General.--This manual instruction addresses payment for preoperative services that are not included in the global surgery payment. Sections 4820 and 4821 of the Medicare Carriers Manual (MCM) describe the preoperative care that is included in the global surgery payment.

B. Non-global Preoperative Services.--Consist of evaluation and management (E/M) services (preoperative examinations) that are not included in the global surgical package and diagnostic tests performed for the purpose of evaluating a patient's risk of perioperative complications and optimizing perioperative care. Medicare will pay for all medically necessary preoperative services as described in §15047, subsections C and D.

C. Non-global Preoperative Examinations.--E/M services performed that are not included in the global surgical package for the purpose of evaluating a patient's risk of perioperative complications and to optimize perioperative care. Preoperative examinations may be billed by using an appropriate CPT code (e.g., new patient, established patient, or consultation). Such non-global preoperative examinations are payable if they are medically necessary and meet the documentation and other requirements for the service billed.

D. Preoperative Diagnostic Tests.--Tests performed to determine a patient's perioperative risk and optimize perioperative care. Preoperative diagnostic tests are payable if they are medically necessary and meet any other applicable requirements.

E. Statutory Basis for Payment.--

1. Section 1862(a)(7) of the Social Security Act (the Act) excludes payment for "routine physical checkups." Both physical examinations and diagnostic tests that are performed in the absence of signs or symptoms of illness or injury may be denied as a routine physical checkup under §1862(a)(7) of the Act. The regulatory provision that further explains this policy is contained in 42 CFR Part 411.15(a)(1).

2. Section 1862(a)(1)(A) of the Act states that no payment will be made for "items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Both physical examinations and diagnostic tests performed in the absence of signs or symptoms can be denied as unnecessary under §1862(a)(1)(A) of the Act.

3. Through previous program and decision memoranda, Medicare has established a clear hierarchy in the application of these two statutory provisions for use in denying payment for physical examinations and diagnostic tests. Claims are initially evaluated against the statutory requirements of §1862(a)(7) of the Act and, if not denied on that basis, they are evaluated against the statutory requirements of §1862 (a)(1)(A). If they meet the statutory requirements of §1862(a)(1)(A) of the Act, they are paid. In general, §1862(a)(1)(A) of the Act is to be invoked only for denying payment for services that are otherwise covered, and are not otherwise excluded from payment, but which are not covered in a particular case because they are not deemed "medically reasonable and necessary" when performed in that specific situation.

15049. OCULAR PHOTODYNAMIC THERAPY (OPT)

Ocular Photodynamic Therapy (OPT) is a treatment for age-related macular degeneration (AMD). Effective January 1, 2001, use CPT code 67221 to bill for OPT. Separate payment is made for any other services, e.g., evaluation and management services, fluorescein angiography, or other ocular diagnostic services, even when provided on the same day as OPT.

The drug, verteporfin (VisudyneTM) was approved by the Food and Drug Administration April 13, 2000, for the treatment of certain forms of AMD. Verteporfin is the first drug approved for OPT. Effective July 1, 2001, verteporfin was approved for inclusion in the United States Pharmacopeia (USP). Therefore, for dates of service beginning July 1, 2001, verteporfin is billed incident to a physician's service under drug code Q3013. When claims are submitted for OPT performed on both eyes on the same day, make a single payment for verteporfin and the infusion of verteporfin, as a single infusion is adequate for treatment of both eyes.

There is no national coverage policy for transpupillary thermal therapy, destruction of macular drusen by photocoagulation and feeder vessel technique (photocoagulation). These procedures should be coded as CPT 67299. Both coverage and payment for these procedures are carrier determined.

15050. ALLERGY TESTING AND IMMUNOTHERAPY

A. Allergy Testing.--Allergy testing services billed under codes 95004-95078 are paid under the Medicare fee schedule for physician services using the national RVUs included in the data base. The RVUs shown for each code are per test. Therefore, instruct physicians to show the quantity of tests provided when billing. Multiply the payment for one test by the quantity for the code.

EXAMPLE: If a physician performs 25 percutaneous tests (scratch, puncture, or prick) with allergenic extract, the physician must bill code 95004 and specify 25 in the units field of Form CMS-1500 (paper claims or electronic format). To compute payment, the Medicare carrier multiplies the payment for one test (i.e., the payment listed in the fee schedule) by the quantity listed in the units field.

B. Allergy Immunotherapy.--For services rendered on or after January 1, 1995, all antigen/allergy immunotherapy services are paid for under the Medicare physician fee schedule. Prior to that date, only the antigen injection services, i.e., only codes 95115 and 95117, were paid for under the fee schedule. Codes representing antigens and their preparation and single codes representing both the antigens and their injection were paid for under the Medicare reasonable charge system. A legislative change brought all of these services under the fee schedule at the beginning of 1995 and the following policies are effective as of January 1, 1995:

1. You are no longer to recognize and physicians are no longer to use the J antigen codes (i.e., J0220, J0230, J0240, J7010, and J7020) or CPT codes 95120 through 95134. Codes 95120 through 95134 represent complete services, i.e., services that include both the injection service as well as the antigen and its preparation.

2. You are to recognize and physicians are to bill only the component codes, i.e., the injection only codes (i.e., codes 95115 and 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170). Pay physicians billing for only the injection service the appropriate code 95115 or code 95117 allowance. Pay physicians billing for only an antigen/antigen preparation service for the appropriate code in the range from 95144 through 95170. Pay physicians providing both services both the injection and the antigen/antigen preparation allowance. This includes allergists who provide both services through the use of treatment boards. They will no longer use the complete service codes and instead are to bill and be paid for both the injection and the antigen services separately, even though the current CPT definitions of the antigen codes refer to vials and the physicians using treatment boards do not create vials.

3. If a physician bills both an injection code plus either codes 95165 or 95144, pay the appropriate injection code (i.e., code 95115 or code 95117) plus the code 95165 rate. When a provider bills for codes 95115 or 95117 plus code 95144, change 95144 to 95165 and pay accordingly. Code 95144 (single dose vials of antigen) should be billed only if the physician providing the antigen is providing it to be injected by some other entity. Single dose vials, which should be used only as a means of insuring proper dosage amounts for injections, are more costly than multiple dose vials (i.e., code 95165) and therefore their payment rate is higher. Allergists who prepare antigens are assumed to be able to administer proper doses from the less costly multiple dose vials. Thus, regardless of whether they use or bill for single or multiple dose vials at the same time that they are billing for an injection service, they are paid at the multiple dose vial rate.

4. The fee schedule amounts for the antigen codes (95144 through 95170) are for a single dose. When billing those codes, physicians are to specify the number of doses provided. When making payment, multiply the fee schedule amount by the number of doses specified in the units field.

5. If a patient's doses are adjusted, e.g., because of patient reaction, and the antigen provided is actually more or fewer doses than originally anticipated, the physician is to make no change in the number of doses for which he or she bills. The number of doses anticipated at the time of the antigen preparation is the number of doses to be billed. This is consistent with the notes on page 30 of the Spring 1994 issue of the American Medical Association's CPT Assistant. Those notes indicate that the antigen codes mean that the physician is to identify the number of doses "prospectively planned to be provided." The physician is to "identify the number of doses scheduled when the vial is provided." This means that in cases where the patient actually gets more doses than originally anticipated (because dose amounts were decreased during treatment) and in cases where the patient gets fewer doses (because dose amounts were increased), no change is to be made in the billing. In the first case, you are not to pay more because the number of doses provided in the original vial(s) increased and in the second case, you are not to seek recoupment (if you have already made payment) because the number of doses is less than originally planned. This is the case for both venom and non-venom antigen codes.

6. Venom Doses and Catch-Up Billing. Venom doses are prepared in separate vials and not mixed together--except in the case of the three vespid mix (white and yellow hornets and yellow jackets). A dose of code 95146 (the two-venom code) means getting some of two venoms. Similarly, a dose of code 95147 means getting some of three venoms; a dose of code 95148 means getting some of four venoms; and a dose of 95149 means getting some of five venoms. Some amount of each of the venoms must be provided. Questions arise when the administration of these venoms does not remain synchronized because of dosage adjustments due to patient reaction. For example, a physician prepares ten doses of code 95148 (the four venom code) in two vials--one containing 10 doses of three vespid mix and another containing 10 doses of wasp venom. Because of dose adjustment, the three vespid mix doses last longer, i.e., they last for 15 doses. Consequently, questions arise regarding the amount of "replacement" wasp venom antigen that should be prepared and how it should be billed. Medicare pricing amounts have savings built into the use of the higher venom codes. Therefore, if a patient is in two venom, three venom, four venom or five venom therapy, your objective is to pay at the highest venom level possible. This means that, to the greatest extent possible, code 95146 is to be billed for a patient in two venom therapy, code 95147 is to be billed for a patient in three venom therapy, code 95148 is to be billed for a patient in four venom therapy, and code 95149 is to be billed for a patient in five venom therapy. Thus, physicians are to be instructed that the venom antigen preparation, after dose adjustment, must be done in a manner that, as soon as possible, synchronizes the preparation back to the highest venom code possible. In the above example, the physician should prepare and bill for only 5 doses of "replacement" wasp venom - billing 5 doses of code 95145 (the one venom code). This will permit the physician to get back to preparing the four venoms at one time and therefore billing the doses of the "cheaper" four venom code. Use of a code below the venom treatment number for the particular patient should occur only for the purpose of "catching up".

7. Code 95165 Doses. Code 95165 represents preparation of vials of non-venom antigens. As in the case of venoms, some non-venom antigens cannot be mixed together, i.e., they must be prepared in separate vials. An example of this is mold and pollen. Therefore, some patients will be injected at one time from one vial - containing in one mixture all of the appropriate antigens - while other patients will be injected at one time from more than one vial. In establishing the practice expense component for mixing a multidose vial of antigens, we observed that the most common practice was to prepare a 10 cc vial; we also observed that the most common use was to remove aliquots with a volume of 1 cc. Our PE computations were based on those facts. Therefore, a physician's removing 10 1 cc aliquot doses captures the entire PE component for the service.

This does not mean that the physician must remove 1 cc aliquot doses from a multidose vial. It means that the practice expenses payable for the preparation of a 10cc vial remain the same irrespective of the size or number of aliquots removed from the vial. Therefore, a physician may not bill this vial preparation code for more than 10 doses per vial; paying for more than 10 doses per multidose vial would significantly overpay the practice expense component attributable to this service. (Note that this code does not include the injection of antigen(s); injections of antigen(s) is separately billable.)

When a multidose vial contains less than 10cc, physicians should bill Medicare for the number of 1 cc aliquots that may be removed from the vial. That is, a physician may bill Medicare up to a maximum of 10 doses per multidose vial, but should bill Medicare for fewer than 10 doses per vial when there is less than 10cc in the vial.

If it is medically necessary, physicians may bill Medicare for preparation of more than one multidose vial.

EXAMPLES:

(1) If a 10cc multidose vial is filled to 6 cc with antigen, the physician may bill Medicare for 6 doses since six 1cc aliquots may be removed from the vial.

(2) If a 5cc multidose vial is filled completely, the physician may bill Medicare for 5 doses for this vial.

(3) If a physician removes ½ cc aliquots from a 10cc multidose vial for a total of 20 doses from one vial, he/she may only bill Medicare for 10 doses. Billing for more than 10 doses would mean that Medicare is overpaying for the practice expense of making the vial.

(4) If a physician prepares two 10cc multidose vials, he/she may bill Medicare for 20 doses. However, he/she may remove aliquots of any amount from those vials. For example, the physician may remove ½ aliquots from one vial, and 1cc aliquots from the other vial, but may bill no more than a total of 20 doses.

(5) If a physician prepares a 20cc multidose vial, he/she may bill Medicare for 20 doses, since the practice expense is calculated based on the physician's removing 1cc aliquots from a vial. If a physician removes 2 cc aliquots from this vial, thus getting only 10 doses, he/she may nonetheless bill Medicare for 20 doses because the PE for 20 doses reflects the actual practice expense of preparing the vial.

(6) If a physician prepares a 5cc multidose vial, he may bill Medicare for 5 doses, based on the way that the practice expense component is calculated. However, if the physician removes 10 ½ cc aliquots from the vial, he/she may still bill only 5 doses because the practice expense of preparing the vial is the same, without regard to the number of additional doses that are removed from the vial.

C. Allergy Shots and Visit Services On Same Day.--At the outset of the physician fee schedule, the question was posed as to whether visits should be billed on the same day as an allergy injection (CPT codes 95115-95117), since these codes have status indicators of A rather than T.

Visits should not be billed with allergy injection services 95115 or 95117 unless the visit represents another separately identifiable service. This language parallels CPT editorial language that accompanies the allergen immunotherapy codes, which include codes 95115 and 95117. Prior to January 1, 1995, you appeared to be enforcing this policy through three (3) different means:

- o Advising physicians to use modifier 25 with the visit service;
- o Denying payment for the visit unless documentation has been provided; and
- o Paying for both the visit and the allergy shot if both are billed for.

For services rendered on or after January 1, 1995, you are to enforce the requirement that visits not be billed and paid for on the same day as an allergy injection through the following means. Effective for services rendered on or after that date, the global surgery policies will apply to all codes in the allergen immunotherapy series, including the allergy shot codes 95115 and 95117. To accomplish this, CMS changed the global surgery indicator for allergen immunotherapy codes from XXX, which meant that the global surgery concept did not apply to those codes, to 000, which means that the global surgery concept applies, but that there are no days in the postoperative global period. Now that the global surgery policies apply to these services, you are to rely on the use of modifier 25 as the only means through which you can make payment for visit services provided on the same day as allergen immunotherapy services. In order for a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series (i.e., any service in the series from 95115 through 95199), the physician is to bill a modifier 25 with the visit code, indicating that the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

D. Reasonable Supply of Antigens.--See §2049.4A regarding the coverage of antigens, including what constitutes a reasonable supply of antigens.

15052. HPSA BONUS PAYMENTS

In HPSA areas, pay physicians an additional 10 percent above the amount paid under the fee schedule (i.e., 10 percent of 80 percent of the lower of the fee schedule or the actual charge). See §3350 for detailed instructions.

15054. NO ADJUSTMENTS

Do not make fee schedule adjustments for:

- Inherent reasonableness (see §5246);
- Comparability (see §5026);
- Multiple visits to nursing homes (i.e., when more than one patient is seen during the same trip) (see §5210);
- Refractions. If you receive a claim for a service that also indicates that a refraction was done, do not reduce payment for the service. CMS has already made the reduction in the RVUs being provided to you. See §§4125 and 5217 for claims processing instructions;

- HCPCS alpha-numeric modifiers AT (acute treatment), ET (emergency treatment), LT (left side of body), RT (right side of body), SF (second opinion ordered by PRO), YY (second surgical opinion), and ZZ (third surgical opinion);

- CPT modifiers 23 (unusual anesthesia), 32 (mandated services), 47 (anesthesia by surgeon), 76 (repeat procedure by same physician), and 90 (reference laboratory); and

- Carrier-unique local modifiers (HCPCS level 3 modifiers beginning with the letters w through z).

15055. ALLOWABLE ADJUSTMENTS

Effective 1/1/2000, the replacement code (CPT 69990) for modifier -20, may be paid separately only when submitted with CPT codes 61304 through 61546, 61550 through 61711, 62010 through 62100, 63081 through 63308, 63704 through 63710, 64831, 64834 through 64836, 64840 through 64858, 64861 through 64870, 64885 through 64898 and 64905 through 64907.

15056. MULTIPLE ADJUSTMENTS

When multiple adjustments apply, see billing guidelines beginning at §4826 for the sequence.

15058. UPDATE FACTOR FOR FEE SCHEDULE SERVICES

CMS provides, on an annual basis, an update factor which you are to apply to update fee schedule amounts. (See §15006.)

Pay for all services rendered in 1992 on the basis of the 1992 fee schedule amounts and for all services rendered prior to 1992 on the basis of the 1991 screens. In processing fee schedule claims in 1993 and beyond, apply the fee schedule screen in effect on the date the service was rendered. However, maintain in your system no more than two update or payment periods, i.e., maintain in your system only the current fee schedule screens and the prior year screens. Therefore, if a service was rendered prior to the date that the prior year screens were in effect, and the claim is only just being processed, pay based on the prior year screen. Note that this seldom, if ever, occurs now that physicians and suppliers are required to submit unassigned claims within 12 months of providing a service.

An example of a mutually exclusive situation is when the repair of the organ can be performed by two different methods. One repair method must be chosen to repair the organ and must be billed. Another

example is the billing of an "initial" service and a "subsequent" service. It is contradictory for a service to be classified as an initial and a subsequent service at the same time.

CPT codes which are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same session can be identified as code pairs. These codes are not necessarily linked to one another with one code narrative describing a more comprehensive procedure compared to the component code, but can be identified as code pairs which should not be billed together.

M. Misuse of Column 2 Code With Column 1 Code.--CPT codes have been written as precisely as possible to not only describe a specific service or procedure but to also avoid describing similar services or procedures which are already defined by other CPT codes. When a CPT code is reported, the physician or non-physician provider must have performed all of the services noted in the descriptor unless the descriptor states otherwise. (Frequently, a CPT descriptor will identify certain services that may or may be included, usually stating “with or without” a service.) A CPT code should not be reported out of the context for which it was intended.

N. Use of Modifiers.--When certain component codes or mutually exclusive codes are appropriately furnished, such as later on the same day or on a different digit or limb, it is appropriate that these services be reported using a HCPCS modifier. Such modifiers are modifiers E1 - E4, FA, F1 - F9, TA, T1 - T9, LT, RT, LC, LD, RC, 58, 59, 78, 79 and 91.

The -59 modifier is not appropriate to use with weekly radiation therapy management codes (77419-77430), nor with evaluation and management services codes (99201-99499).

Application of these modifiers prevent erroneous denials of claims for several procedures performed on different anatomical sites, on different sides of the body, or at different sessions on the same date of service. The medical record must reflect that the modifier is being used appropriately to describe separate services. (See §4630 for implementation related instructions.)

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15360. ECHOCARDIOGRAPHY SERVICES (CODES 93303 - 93350)

A. Separate Payment for Contrast Media.--Effective October 1, 2000, physicians may separately bill for contrast agents used in echocardiography. Physicians should use HCPCS Code A9700 (Supply of injectable contrast material for use in echocardiography, per study). The type of service code is 9. This code will be carrier-priced.

15400. CHEMOTHERAPY ADMINISTRATION (CODES 96400-96549)

A. General Use of Codes.--Chemotherapy administration codes, 96400 through 96450, 96542, 96545, and 96549, are only to be used when reporting chemotherapy administration when the drug being used is an antineoplastic and the diagnosis is cancer. The administration of other drugs, such as growth factors, saline, and diuretics, to patients with cancer, or the administration of antineoplastics to patients with a diagnosis other than cancer, are reported with codes 90780 through 90784 as appropriate.

B. Chemotherapy Administration By Push and Infusion On Same Day.--Separate payment is allowed for chemotherapy administration by push and by infusion technique on the same day. Allow only one push administration on a single day.

C. Chemotherapy Infusion and Hydration Therapy Infusion On Same Day.--Separate payment is not allowed for the infusion of saline, an antiemetic, or any other nonchemotherapy drug under CPT codes 90780 and 90781 when administered at the same time as chemotherapy infusion (CPT codes 96410, 96412, or 96414). Separate payment is allowed for these two services on the same day when they are provided sequentially, rather than at the same time. Physicians use the modifier -GB to indicate when CPT codes 90780 and 90781 are provided sequentially with CPT codes 96410, 96412, and 96414.

D. Chemotherapy Administration and "Incident To" Services on Same Day.--On days when a patient receives chemotherapy administration but the physician has no face-to-face contact with the patient, the physician may report and be paid for "incident to" services furnished by one of the physician's employees, in addition to the chemotherapy administration, if they are furnished under direct personal supervision in the office by one of the physician's employees and the medical records reflect the physician's active participation in and management of the course of treatment. The correct code for this service is 99211.

E. Flushing Of Vascular Access Port.--Flushing of a vascular access port prior to administration of chemotherapy is integral to the chemotherapy administration and is not separately billable. If a special visit is made to a physician's office just for the port flushing, code 99211, brief office visit, should be used. Code 96530, refilling and maintenance of implantable pump or reservoir, while a payable service, should not be used to report port flushing.

F. Chemotherapy Administration and Hydration Therapy.--Do not pay separately for the infusion of saline, an antiemetic, or any other nonchemotherapy drug under codes 90780 and 90781 when these drugs are administered at the same time as chemotherapy infusion, codes 96410, 96412, or 96414. However, pay for the infusion of saline, antiemetics, or other nonchemotherapy drugs under codes 90780 and 90781 when these drugs are administered on the same day but sequentially to rather than at the same time as chemotherapy infusion, codes 96410, 96412, and 96414. Physicians should use modifier GB to indicate when codes 90780 and 90781 are provided sequentially rather than contemporaneously with codes 96410, 96412, and 96414. Both the chemotherapy and the nonchemotherapy drugs are payable regardless of whether they are administered sequentially or contemporaneously.

15501. EVALUATION AND MANAGEMENT SERVICE CODES - GENERAL (CODES 99201-99499)

A. Use Of CPT Codes.--Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

B. Selection of Level Of Evaluation and Management Service.--Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services)is spent providing counseling or coordination of care as described in subsection C.

The physician or any non-physician practitioner with the ability to bill Medicare services must submit his/her bill to reflect the actual service or portion of a service he/she performed. When a service performed is less than the CPT description of the level of the service, the physician and/or the non-physician practitioner must document and bill the service he/she individually provided. A claim for a service must always reflect the service actually provided. A physician and/or non-physician practitioner may submit a claim for CPA code 99499, Unlisted Evaluation and Management Service with a detailed report stating why the covered service was medically necessary and describing what service(s) was provided. The carrier has the discretion to value the service when the service does not meet the full terms of the CPT description (e.g., only a history is performed). The carrier will also determine the payment based on the applicable percentage of the physician fee schedule depending on whether the claim is paid at the physician rate or the limited licensed practitioner rate. CPT modifier -52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier -52 for this purpose.

C. Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling.{tc \l2 "C. Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling.}--Advise physicians that when counseling and/or coordination of care dominates (more than 50%) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment

options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face to face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

- When pre-operative critical care codes are being billed on the date of the procedure, the diagnosis must support that the service is unrelated to the performance of the procedure (see §15508.G.); or

- When a carrier has conducted a specific medical review process and determined, after reviewing the data, that an individual or a group has high use of modifier 25 compared to other physicians, has done a case-by-case review of the records to verify that the use of modifier was inappropriate, and has educated the individual or group, the carrier may impose pre-payment screens or documentation requirements for that provider or group.

Do not permit the use of CPT modifier 25 to generate payment for multiple evaluation and management services on the same day by the same physician, notwithstanding the CPT definition of the modifier.

C. CPT Modifier 57 - Decision For Surgery Made Within Global Surgical Period.--Pay for an evaluation and management service on the day of or on the day before a procedure with a 90 day global surgical period if the physician uses CPT modifier 57 to indicate that the service was for the decision to perform the procedure. Do not pay for an evaluation and management service billed with the CPT modifier 57 if it was provided on or the day before a procedure with a 0 or 10 day global surgical period.

15502. PAYMENT FOR OFFICE/OUTPATIENT VISITS (CODES 99201-99215)

A. Definition of New Patient For Selection Of Visit Code.--Interpret the phrase "new patient" to mean a patient who has not received any professional services from the physician within the previous 3 years. (See definition of physicians in group practice in Section 15501H.)

If no face to face encounter has previously occurred between the physician and the patient, then the patient may be coded as a new patient the first time a face to face encounter does occur. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed but a face to face encounter does not take place, then this patient remains a new patient for whenever the initial evaluation and management service occurs. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of a face to face encounter does not affect the new patient designation.

B. Office/Outpatient Visits Provided On Same Day For Unrelated Problems.--Do not pay two office visits billed by a physician for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office or outpatient setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed 5 hours later by a visit for evaluation of leg pain following an accident).

C. Office/Outpatient or Emergency Department Visit On Day Of Admission To Nursing Facility.--Do not pay a physician for an emergency department visit or an office visit and a comprehensive nursing facility assessment on the same day. Bundle evaluation and management services on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician. (See §15509.)

D. Injection and Evaluation and Management Code Billed Separately on Same Day of Service.--Advise physicians that CPT code 99211 cannot be used to report a visit solely for the purpose of receiving an injection which meets the definition of CPT codes 90782, 90783, 90784, or 90788. Do not pay CPT codes 90782, 90783, 90784, or 90788 if any other physician fee schedule service was rendered.

The drug is billed as a J code, whether the injection is separately billable or not.

If no evaluation and management service or other service is provided on the same day as the injection, the injection code is billed.

15504. PAYMENT FOR HOSPITAL OBSERVATION SERVICES (CODES 99217-99220)

A. Who May Bill Initial Observation Care.--Pay for initial observation care billed by only the physician who admitted the patient to hospital observation and was responsible for the patient during his/her stay in observation. A physician who does not have inpatient admitting privileges but who is authorized to admit a patient to observation status may bill these codes.

For a physician to bill the initial observation care codes, there must be a medical observation record for the patient which contains dated and timed physician's admitting orders regarding the care the patient is to receive while in observation, nursing notes, and progress notes prepared by the physician while the patient was in observation status. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.

Payment for an initial observation care code is for all the care rendered by the admitting physician on the date the patient was admitted to observation. All other physicians who see the patient while he or she is in observation must bill the office and other outpatient service codes or outpatient consultation codes as appropriate when they provide services to the patient.

For example, if an internist admits a patient to observation and asks an allergist for a consultation on the patient's condition, only the internist may bill the initial observation care code. The allergist must bill using the outpatient consultation code that best represents the services he or she provided. The allergist cannot bill an inpatient consultation since the patient was not a hospital inpatient.

B. Physician Billing For Observation Care Following Admission To Observation.--If the patient is discharged on the same date as admission to observation, pay only the initial observation care code because that code represents a full day of care.

If the patient remains in observation after the first date following the admission to observation, it is expected that the patient would be discharged on that second calendar date. The physician bills CPT code 99217 for observation care discharge services provided on the second date.

In the rare circumstance when a patient is held in observation status for more than two calendar dates, the physician must bill subsequent services furnished before the date of discharge using the outpatient/office visit codes. The physician may not use the subsequent hospital care codes since the patient is not an inpatient of the hospital.

C. Admission To Inpatient Status From Observation.--If the same physician who admitted a patient to observation status also admits the patient to inpatient status from observation before the end of the date on which the patient was admitted to observation, pay only an initial hospital visit for the evaluation and management services provided on that date. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill an initial observation care code for services on the date that he or she admits the patient to inpatient status. If the patient is admitted to inpatient status from observation subsequent to the date of admission to observation, the physician must bill an initial hospital visit for the services provided on that date. The physician may not bill the hospital observation discharge management code (code 99217) or an outpatient/office visit for the care provided in observation on the date of admission to inpatient status.

D. Hospital Observation During Global Surgical Period.--The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, and 99220) services unless the criteria for use of CPT modifiers 24, 25, or 57 are met. Pay for these services in addition to the global surgical fee only if both of the following requirements are met:

D. Transfer From One Hospital To Another By Same Physician; Transfer Within Facility To Prospective Payment System (PPS) Exempt Unit of Hospital; Transfer From One Facility To Another Separate Entity Under Same Ownership and/or Part of Same Complex; or Transfer From One Department To Another Within Single Facility.--Advise physicians that they may bill both the hospital discharge management code and an initial hospital care code when the discharge and admission do not occur on the same day if the transfer is between (1) different hospitals, (2) different facilities under common ownership which do not have merged records, or (3) between the acute care hospital and a PPS exempt unit within the same hospital when there are no merged records.

In all other transfer circumstances, the physician should bill only the appropriate level of subsequent hospital care for the date of transfer.

E. Initial Hospital Care Service History and Physical That Is Less Than Comprehensive.--Advise physicians that when a physician performs a visit or consultation that meets the definition of a level 5 office visit or consultation several days prior to an admission and then on the day of admission performs less than a comprehensive history and physical, he or she should report the office visit or consultation that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code 99221) for the initial hospital admission. Pay the office visit as billed and the level 1 initial hospital care code.

F. Initial Hospital Care Visits by Two Different M.D.s or D.O.s When They Are Involved in Same Admission.--Advise physicians to use the initial hospital care codes (codes 99221-99223) to report the first hospital inpatient encounter with the patient when he or she is the admitting physician.

Consider only one M.D. or D.O. to be the admitting physician and permit only the admitting physician to use the initial hospital care codes. Advise physicians that if they participate in the care of a patient but are not the admitting physician of record, they should bill the inpatient evaluation and management services codes that describe their participation in the patient's care (i.e., subsequent hospital visit or inpatient consultation).

G. Initial Hospital Care and Nursing Facility Visit on Same Day.--Pay only the initial hospital care code if the patient is admitted to a hospital following a nursing facility visit on the same date by the same physician. Instruct physicians that they may not report a nursing facility service and an initial hospital care service on the same day. Payment for the initial hospital care service includes all work performed by the physician in all sites of service on that date.

15505.2 Subsequent Hospital Visit and Hospital Discharge Management (Codes 99231-99239).--

A. Subsequent Hospital Visit and Discharge Management on Same Day.--Pay only the hospital discharge management code on the day of discharge (unless it is also the day of admission, in which case, the admission service and not the discharge management service is billed). Do not pay both a subsequent hospital visit in addition to hospital discharge day management service on the same day by the same physician. Instruct physicians that they may not bill for both a hospital visit and hospital discharge management for the same date of service.

B. Hospital Discharge Management (CPT Codes 99238 and 99239) and Nursing Facility Admission Code When Patient Is Discharged From Hospital and Admitted To Nursing Facility on Same Day.--Pay the hospital discharge code (codes 99238 or 99239) in addition to a nursing facility admission code when they are billed by the same physician with the same date of service.

If a surgeon is admitting the patient to the nursing facility due to a condition that is not as a result of the surgery during the post-operative period of a service with the global surgical period, he/she bills for the nursing facility admission and care with a -24 modifier and provides documentation that the service is unrelated to the surgery (e.g., return of an elderly patient to the nursing facility in which he/she has resided for 5 years following discharge from the hospital for cholecystectomy).

Do not pay for a nursing facility admission by a surgeon in the postoperative period of a procedure with a global surgical period if the patient's admission to the nursing facility is to receive post operative care related to the surgery (e.g., admission to a nursing facility to receive physical therapy following a hip replacement). Payment for the nursing facility admission and subsequent nursing facility services are included in the global fee and cannot be paid separately.

15506. CONSULTATIONS (Codes 99241 - 99275)

Do not pay for a nursing facility admission by a surgeon in the postoperative period of a procedure with a global surgical period if the patient's admission to the nursing facility is to receive post operative care related to the surgery (e.g., admission to a nursing facility to receive physical therapy following a hip replacement). Payment for the nursing facility admission and subsequent nursing facility services are included in the global fee and cannot be paid separately.

A. Consultation Versus Visit.--Pay for a consultation when all of the criteria for the use of a consultation code are met:

(1) Specifically, a consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (unless it is a patient-generated confirmatory consultation).

(2) A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.

(3) After the consultation is provided, the consultant prepares a written report of his/her findings which is provided to the referring physician.

Consultations may be billed for time if the counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician and the patient. The preceding requirements must also be met.

B. Consultation Followed By Treatment.--Pay for an initial consultation if all the criteria for a consultation are satisfied. Payment may be made regardless of treatment initiation unless a transfer of care occurs. A transfer of care occurs when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance. The receiving physician would report a new or established patient visit depending on the situation (a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years) and setting (e.g., office or inpatient).

A physician consultant may initiate diagnostic and/or therapeutic services at an initial or subsequent visit. Subsequent visits (not performed to complete the initial consultation) to manage a portion or all of the patient's condition should be reported as established patient office visit or subsequent hospital care, depending on the setting.

C. Consultations Requested by Members of Same Group.--Pay for a consultation if one physician in a group practice requests a consultation from another physician in the same group practice as long as all of the requirements for use of the CPT consultation codes are met. (See §§15506A and 15501.H.)

Non-physician practitioners, e.g., nurse practitioners, certified nurse-midwives or physician assistants, may request a consultation. They may also perform other medically necessary services, e.g., consultations when the performance is within the scope of practice for that type of non-physician practitioner in the State in which they practice. Applicable collaboration and general supervision rules apply as well as billing rules.

D. Documentation for Consultations.—A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record. A written report must be furnished to the requesting physician.

In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the referring physician and the consultant, the request may be documented as part

15509.1 Payment For Physician's Visits To Residents Of Skilled Nursing Facilities and Nursing Facilities.--

A. Visits to Perform Resident Assessments.--Pay for visits necessary to perform all Medicare required assessments. Physicians should use the CPT codes for comprehensive nursing facility assessments (99301-99303) to report evaluation and management services involving comprehensive resident assessments. Evaluation and Management documentation guidelines apply. (See §15510 for further clarification on use of SNF/NF codes.)

B. Visits to Comply With Federal Regulations (42 CFR 483.40).--Pay for visits required to monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. These visits and all other medically necessary visits for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are covered under Medicare Part B. Physicians should use CPT codes for subsequent nursing facility care (99311-99313) when reporting evaluation and management services that do not involve resident assessments. Medicare does not pay for additional visits required by State law for an admission unless the visits are necessary to meet the medical needs of the individual resident.

C. Medically Complex Care.--Pay for visits to residents in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are medically necessary and documented in the medical record. Physicians should use CPT codes for subsequent nursing facility care (99311-99313) when reporting evaluation and management services.

D. Visits by Non-Physician Practitioners.--Visits to comply with Federal Regulations (see 15509.1B) in SNFs after the initial visit by the physician may, at the option of the physician, be provided by a non-physician practitioner, i.e., physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS). (Refer to 42 CFR 483.40(4) and (e).)

Any medically necessary physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied, when performed by an NP, PA or CNS (at the option of the State) who is not an employee of the facility in which they practice. (Refer to 42 CFR 483.40 (f).)

Where a physician establishes an office in a SNF/NF, the "incident to" services and requirements are confined to this discrete part of the facility designated as his/her office. "Incident to" services may not be billed in a hospital setting. Thus, services performed outside the "office" area would be subject to the coverage rules applicable to services provided outside the office setting, i.e., nursing home. (Refer to CIM 45-15.)

Services provided by physician-employed or independent non-physician practitioners must meet Medicare requirements and fall within the scope of services that practitioners are licensed to perform. A physician assistant must be under the general supervision of the physician. These visits and all other medically necessary visits for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are covered under Medicare Part B.

E. Gang Visits.--Although the selection of the level of service for an evaluation and management encounter is not based on time, the CPT codes provide an approximate time typically spent with a resident. The level of service and code billed must be medically necessary (§§1862 (a)(1)(A)of the Social Security Act) for each resident. Claims for an unreasonable number of visits to residents at a facility within a 24-hour period may indicate an aberrancy and result in medical review to determine medical necessity. Medical records must document the specific services to each individual resident.

15510. HOME CARE AND DOMICILIARY CARE VISITS (CODES 99321 - 99353)

A. Physician Visits to Patients Residing in Various Places of Service.--Current Procedural Terminology (CPT) codes 99321 through 99333, Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services, are used to report evaluation and management (E/M) services to residents residing in a facility which provides, room, board, and other personal assistance services, generally on a long- term basis. These codes are limited to the specific two digit places of service (POS) 33 (Custodial Care Facility) and 55 (Residential Substance Abuse Facility). These facilities, also, often referred to as adult living facilities or assisted living facilities.

Physicians and providers furnishing E/M services to residents in a living arrangement described by one of the POS listed above must use the level of service code in the range of codes 99321- 99333 to report the service they provide.

CPT codes 99341 through 99350, Home Services codes, are used to report E/M services furnished to a patient residing in his or her own private residence and not any type of facility. These codes apply only to the specific two digit POS 12 (Patient's Home). Home Services codes, CPT codes 99341 through 99350, may not be used for billing for E/M services provided other than in the private residence of an individual.

E/M services provided to patients residing in a Skilled Nursing Facility (SNF) (CPT) definition formerly identified as SNFs, intermediate care facilities (ICFs), or long term care facilities (LTCFs) must be reported using the appropriate level of service code within the range identified for Comprehensive Nursing Facility Assessments and Subsequent Nursing Facility Care services. Codes range from 99301 through 99303 for the former and 99311 through 99313 for the latter, and Nursing Facility Discharge Services codes 99315 - 99316. These codes are limited to the specific two digit POS 31 (SNF), 32 (Nursing Home/Nursing Facility), 54 (Intermediate Care Facility/Mentally Retarded) and 56 (Psychiatric Residential Treatment Center).

The nursing facility codes should be used with POS 31 if the patient is in a Part A SNF stay and POS 32 if the patient does not have Part A SNF benefits.

15511. PROLONGED SERVICES AND STANDBY SERVICES (CODES 99354-99360)

15511.1 Prolonged Services (Codes 99354 - 99355).--

A. Required Companion Codes.--Pay prolonged services codes 99354-99355 when they are billed on the same day by the same physician as the companion evaluation and management codes and:

- The companion codes for 99354 are 99201-99205, 99212-99215, 99241-99245; or 99341- 99345; 99347 - 99350 to be used;

- The companion codes for 99355 are 99354 and one of the evaluation and management codes required for 99354 to be used;

- The companion codes for 99356 are 99221-99223, 99231-99233, 99251-99255, 99261-99263, 99301-99303, or 99311-99313; or

- The companion codes for 99357 are 99356 and one of the evaluation and management codes required for 99357 to be used.

Do not pay prolonged services codes 99354-99358 unless they are accompanied by one of these companion codes.

B. Requirement for Physician Presence.--Advise physicians to count only the duration of direct face-to-face contact between the physician and the patient (whether the service was continuous or not) beyond the typical time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable. In the case of prolonged office services, time spent by office staff with the patient, or time the patient remains unaccompanied in the office cannot be billed. In the case of prolonged hospital services, time spent waiting for test results, for changes in the patient's condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services.

C. Documentation.--Do not require documentation to accompany the bill for prolonged services unless the physician has been targeted for medical review. Advise physicians that to support billing for prolonged services, the medical record must document the duration and content of the evaluation and management code billed and that the physician have personally furnished at least 30 minutes of direct service after the typical time of the evaluation and management service had been exceeded by at least 30 minutes.

D. Use of the Codes.--Advise physicians that prolonged services codes can be billed only if the total duration of all physician direct face-to-face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician provided (typical time plus 30 minutes). If the total duration of direct face-to-face time does not equal or exceed the threshold time for the level of evaluation and management service the physician provided, the physician may not bill for prolonged services.

E. Threshold Times for Codes 99354 and 99355.--If the total direct face-to-face time equals or exceeds the threshold time for code 99354, but is less than the threshold time for code 99355, the physician should bill the visit and code 99354. Do not accept more than 1 unit of code 99354. If the total direct face-to-face time equals or exceeds the threshold time for code 99355 by no more than 29 minutes, the physician should bill the visit code 99354 and one unit of code 99355. One additional unit of code 99355 is billed for each additional increment of 30 minutes extended duration. Use the following threshold times to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office/outpatient visit and consultation codes.

Code	Typical time for code	Threshold time to bill code 99354	Threshold time to bill codes 99354 and 99355
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99241	15	45	90
99242	30	60	105
99243	40	70	115
99244	60	90	135
99245	80	110	155
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

Add 30 minutes to the threshold time for billing codes 99354 and 99355 to get the threshold time for billing code 99354 and 2 units of code 99355. For example, to bill code 99354 and 2 units of code 99355 when billing a code 99205, the threshold time is 150 minutes.

F. Threshold Times for Codes 99356 and 99357.--If the total direct face-to-face time equals or exceeds the threshold time for code 99356, but is less than the threshold time for code 99357, the physician should bill the visit and code 99356. Do not accept more than 1 unit of code 99356. If the total direct face-to-face time equals or exceeds the threshold time for code 99356 by no more than 29 minutes, the physician bills the visit code 99356 and one unit of code 99357. One additional unit of code 99357 is billed for each additional increment of 30 minutes extended duration. Use the following threshold times to determine if the prolonged services codes 99356 and/or 99357 can be billed with the office/outpatient visit and consultation codes.

Code	Threshold time for code	Threshold time to bill code 99356	Threshold time to bill codes 99356 and 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110

Code	Typical time for code	Threshold time to bill code 99356	Threshold time to bill codes 99356 and 99357
99251	20	50	95
99252	40	70	115
99253	55	85	130
99254	80	110	155
99255	110	140	185
99261	10	40	85
99262	20	50	95
99263	30	60	105
99301	30	60	105
99302	40	70	115
99303	50	80	125
99311	15	45	90
99312	25	55	100
99313	35	65	110

Add 30 minutes to the threshold time for billing codes 99356 and 99357 to get the threshold time for billing code 99356 and 2 units of 99357.

G. Examples of Billable Prolonged Services.--

1. A physician performed a visit that met the definition of visit code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills code 99213 and 1 unit of code 99354.

2. A physician performed a visit that met the definition of visit code 99303 and the total duration of the direct face-to-face contact (including the visit) was 115 minutes. The physician bills codes 99303, 99356, and 1 unit of code 99357.

H. Examples of Nonbillable Prolonged Services.--

1. A physician performed a visit that met the definition of visit code 99212 and the total duration of the direct face-to-face contact (including the visit) was 35 minutes. The physician cannot bill prolonged services because the total duration of direct face to face service did not meet the threshold time for billing prolonged services.

2. A physician performed a visit that met the definition of code 99213 and, while the patient was in the office receiving treatment for 4 hours, the total duration of the direct face-to-face service of the physician was 40 minutes. The physician cannot bill prolonged services because the total duration of direct face to face service did not meet the threshold time for billing prolonged services.

15511.2 Prolonged Services Without Face-to-Face Service (Codes 99358-99359).--Do not pay prolonged services codes 99358 and 99359, which do not require any direct patient contact. Payment for these services is included in the payment for direct face to face services that physicians bill. The physician cannot bill the patient for these services since they are Medicare covered services and payment is included in the payment for other billable services.

2001 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	Work	Practice Expense	Mal-practice
00510	00	ALABAMA	0.978	0.871	0.841
00831	01	ALASKA	1.063	1.172	1.378
00832	00	ARIZONA	0.994	0.975	1.150
00520	13	ARKANSAS	0.953	0.851	0.371
02050	26	ANAHEIM/SANTA ANA, CA	1.036	1.187	0.901
02050	18	LOS ANGELES, CA	1.055	1.169	0.901
31140	03	MARIN/NAPA/SOLANO, CA	1.014	1.205	0.677
31140	07	OAKLAND/BERKELEY, CA	1.040	1.216	0.677
31140	05	SAN FRANCISCO, CA	1.067	1.378	0.677
31140	06	SAN MATEO, CA	1.047	1.353	0.677
31140	09	SANTA CLARA, CA	1.062	1.321	0.653
02050	17	VENTURA, CA	1.027	1.128	0.750
02050	99	REST OF CALIFORNIA*	1.007	1.039	0.723
31140	99	REST OF CALIFORNIA*	1.007	1.039	0.723
00824	01	COLORADO	0.986	0.981	0.817
10230	00	CONNECTICUT	1.049	1.164	1.009
00902	01	DELAWARE	1.019	1.032	0.786
00903	01	DC + MD/VA SUBURBS	1.050	1.164	0.970
00590	03	FORT LAUDERDALE, FL	0.996	1.022	1.830
00590	04	MIAMI, FL	1.015	1.064	2.439
00590	99	REST OF FLORIDA	0.975	0.947	1.296
00511	01	ATLANTA, GA	1.006	1.046	0.943
00511	99	REST OF GEORGIA	0.970	0.896	0.943
00833	01	HAWAII/GUAM	0.997	1.154	0.894
05130	00	IDAHO	0.960	0.887	0.532
00952	16	CHICAGO, IL	1.027	1.090	1.745
00952	12	EAST ST. LOUIS, IL	0.988	0.927	1.589
00952	15	SUBURBAN CHICAGO, IL	1.006	1.069	1.505
00952	99	REST OF ILLINOIS	0.964	0.888	1.074
00630	00	INDIANA	0.981	0.919	0.445
00826	00	IOWA	0.959	0.879	0.622
00650	00	KANSAS*	0.963	0.897	0.823
00740	04	KANSAS*	0.963	0.897	0.823
00660	00	KENTUCKY	0.970	0.870	0.842
00528	01	NEW ORLEANS, LA	0.998	0.947	1.218
00528	99	REST OF LOUISIANA	0.969	0.876	1.052
31142	03	SOUTHERN MAINE	0.979	1.015	0.687
31142	99	REST OF MAINE	0.961	0.917	0.687
00901	01	BALTIMORE/SURR. CNTYS, MD	1.020	1.038	1.007
00901	99	REST OF MARYLAND	0.985	0.979	0.820

2001 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	Work	Practice Expense	Mal-practice
31143	01	METROPOLITAN BOSTON	1.040	1.218	0.748
31143	99	REST OF MASSACHUSETTS	1.010	1.111	0.748
00953	01	DETROIT, MI	1.042	1.030	2.903
00953	99	REST OF MICHIGAN	0.996	0.938	1.700
10240	00	MINNESOTA	0.990	0.971	0.479
10250	00	MISSISSIPPI	0.957	0.841	0.750
00740	02	METROPOLITAN KANSAS CITY, MO	0.988	0.958	1.021
00523	01	METROPOLITAN ST. LOUIS, MO	0.994	0.940	1.022
00740	99	REST OF MISSOURI*	0.946	0.826	0.979
00523	99	REST OF MISSOURI*	0.946	0.826	0.979
00751	01	MONTANA	0.951	0.877	0.729
00655	00	NEBRASKA	0.949	0.875	0.436
00834	00	NEVADA	1.005	1.035	1.103
31144	40	NEW HAMPSHIRE	0.987	1.032	0.919
00805	01	NORTHERN NJ	1.057	1.192	0.827
00805	99	REST OF NEW JERSEY	1.028	1.102	0.827
00521	05	NEW MEXICO	0.973	0.905	0.809
00803	01	MANHATTAN, NY	1.093	1.352	1.661
00803	02	NYC SUBURBS/LONG I., NY	1.067	1.242	1.942
00803	03	POUGHKPSIE/N NYC SUBURBS, NY	1.010	1.079	1.300
14330	04	QUEENS, NY	1.057	1.231	1.855
00801	99	REST OF NEW YORK	0.998	0.951	0.778
05535	00	NORTH CAROLINA	0.970	0.927	0.546
00820	01	NORTH DAKOTA	0.950	0.879	0.657
16360	00	OHIO	0.989	0.941	1.016
00522	00	OKLAHOMA	0.969	0.879	0.447
00835	01	PORTLAND, OR	0.996	1.035	0.511
00835	99	REST OF OREGON	0.961	0.935	0.511
00865	01	METROPOLITAN PHILADELPHIA, PA	1.023	1.090	1.310
00865	99	REST OF PENNSYLVANIA	0.989	0.930	0.705
00973	20	PUERTO RICO	0.882	0.720	0.317
00870	01	RHODE ISLAND	1.017	1.067	1.036
00880	01	SOUTH CAROLINA	0.975	0.905	0.279
00820	02	SOUTH DAKOTA	0.935	0.876	0.420
05440	35	TENNESSEE	0.975	0.900	0.572
00900	31	AUSTIN, TX	0.986	0.998	0.854
00900	20	BEAUMONT, TX	0.992	0.895	1.362
00900	09	BRAZORIA, TX	0.992	0.978	1.362
00900	11	DALLAS, TX	1.010	1.040	0.930
00900	28	FORT WORTH, TX	0.987	0.976	0.930

2001 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	Work	Practice Expense	Mal-practice
00900	15	GALVESTON, TX	0.988	0.969	1.362
00900	18	HOUSTON, TX	1.020	1.007	1.377
00900	99	REST OF TEXAS	0.966	0.884	0.914
00910	09	UTAH	0.977	0.925	0.619
31145	50	VERMONT	0.973	0.985	0.544
00973	50	VIRGIN ISLANDS	0.965	1.029	1.017
10490	00	VIRGINIA	0.985	0.939	0.529
00836	02	SEATTLE (KING CNTY), WA	1.005	1.090	0.765
00836	99	REST OF WASHINGTON	0.982	0.974	0.765
16510	16	WEST VIRGINIA	0.963	0.852	1.242
00951	00	WISCONSIN	0.981	0.931	0.890
00825	21	WYOMING	0.967	0.895	0.855

* Payment locality is serviced by two carriers.