Medicare
Carriers Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2622

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
15064 -15066 15350 -15501 (Cont.)	15-55 - 15-56 (2 pp.) 15-73 - 15-74.2 (4 pp.)	15-55 - 15-56 (2 pp.) 15-73 - 15-74.2 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: October 1, 2003*
IMPLEMENTATION DATE: October 1, 2003

Section 15062.1, Payment for Physician Services Furnished to Dialysis Inpatients, is revised to clarify a CPT Editorial change in the description for CPT codes 90935 and 90937. The change in the code descriptor allows for these codes to be used for outpatient acute dialysis services (that is, patients who are expected to regain their renal function) as well as for inpatient ESRD and acute dialysis services.

Section 15350, Dialysis Services (Codes 90935-90999), adds a new subsection allowing payment for CPT codes 90935 or 90937 for dialysis services furnished to acute dialysis patients requiring hemodialysis on an outpatient or inpatient basis.

Carriers must share the following information with providers through a posting on their Web site within two weeks of receiving this instruction and publish in their next regularly scheduled bulletin. If you have a list-serv that targets the affected provider community, you should use it to notify subscribers that information about outpatient/inpatient services for non-ESRD dialysis services is available on your Web site.

Refer to the revised payment policy change in MCM Section 15350, Inpatient and Outpatient Dialysis Services On Same Date as An Evaluation and Management Service.

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.

- The services must be medically necessary; and
- The payment for the services must be reasonably related to the nature of the services actually furnished.

2. Physicians' Services - Criteria for Procedure Codes.--The procedure code covers the full range of physicians' renal-related services furnished during an inpatient dialysis treatment.

In order to be paid on the basis of a procedure code, the physician must have been physically present with the patient at some time during the course of the dialysis, and the medical record (e.g., the physician's progress note or the nurse's notes in the patient's hospital medical record) must document this.

If the physician visits the dialysis inpatient on a dialysis day, but not during the dialysis treatment, do not pay the physician on the basis of a procedure code. The nature of these services is the same as physicians' services furnished to any inpatient during a hospital visit. Therefore, use the same hospital visit codes that apply to any other physicians treating hospital inpatients.

Physicians' services furnished to patients who are dialyzed as inpatients because there is no room in the outpatient dialysis units are covered under the MCP, and physicians are not paid amounts in addition to or in place of the MCP. (See §15062.1.B.)

3. Peritoneal Dialysis.--Peritoneal dialysis is typically furnished in extended periods. For example, CAPD is continuous, and the patient may actually be dialyzed 7 days per week. IPD may be furnished in extended periods of 30 hours or more. The fact that a patient is dialyzed continuously for an extended period does not justify payment in excess of the average weekly allowance made for hemodialysis services. Payment in excess of this amount is made only if you determine that the same kind and intensity of physicians' hemodialysis treatment beyond the number ordinarily furnished in a 7-day period, and the patient's condition was similar to that of a hemodialysis patient who would have required these additional services.

D. Billing Codes.--Except when the MCP applies, (see §15062.1B) claims for physicians' inpatient dialysis services furnished to ESRD or acute dialysis patients are processed using inpatient dialysis services procedure codes 90935, 90937, 90945, and 90947 according to the rules in §15062.1C.

Beginning October1, 2003, claims for physicians' services for outpatient acute hemodialysis services will be processed using codes 90935 and 90937 according to the rules in §15350B. Prior to this date, these codes were used for acute dialysis services only when it was furnished on an inpatient basis. All carriers must use these codes for these services.

15064. COMPARABILITY OF PAYMENT PROVISION OF DELEGATION OF AUTHORITY BY CMS TO RAILROAD RETIREMENT BOARD

The delegation of authority, under which the Railroad Retirement Board (RRB) administers the Supplementary Medical Insurance Benefits Program for qualified railroad retirement beneficiaries, requires that:

> "The Railroad Retirement Board shall take such action as may be necessary to assure that payments made for services by the intermediaries it selects will conform as closely as possible to the payment made for comparable services in the same locality by an intermediary acting for the Centers for Medicare and Medicaid Services (CMS)."

The purpose of this comparability of payment is to reduce to the extent possible disparities between the payments made by the carrier under the RRB delegation and the payments made by the regular area carriers for services or items furnished by the same physicians, including provider-based physicians, or suppliers. For all services paid for under the physician fee schedule, carriers under the RRB delegation pay based on the same fee schedule amount used by the area carrier.

15066. FEE SCHEDULE PAYMENT FOR SERVICES TO HOMEBOUND PATIENTS UNDER GENERAL SUPERVISION

The coverage guidelines in §2051 permit payment to be made under certain conditions for injections, EKGs, and venipunctures that are performed for homebound patients under general physician supervision by nurses and paramedical employees of physicians or physician-directed clinics.

15068. CORRECT CODING POLICY

Section 4501 provides the basis for the Healthcare Common Procedure Coding System (HCPCS) that physicians and others must use to report the services they provide to Medicare beneficiaries. The HCPCS system contains three levels of codes. Level I contains the American Medical Association's Current Procedural Terminology (CPT) numeric codes. Level II contains alpha-numeric codes primarily for items and services not included in CPT. Level III contains carrier specific codes that are not included in either Level I or Level II.

The CPT (Level I) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The codes are updated annually by the CPT Editorial Panel based on input from the AMA Advisory Committee which serves as a channel for requests from various providers and specialty societies. The purpose of the coding system and annual update is to communicate specific services rendered by physicians, usually for the purpose of claim submission to third party (insurance) carriers. A multitude of codes are necessary because of the wide spectrum of services provided by various medical care providers. Because many medical services can be rendered by different methods and combinations of various procedures, multiple codes describing similar services are frequently necessary to accurately reflect what service a physician performs. While often only one procedure is performed at a patient encounter, multiple procedures are performed at the same session at other times.

CMS as well as many third party payers have adopted the CPT coding system for use by physicians and others to describe services rendered. The following general coding policies encompass coding principles that are to be applied in the review of Medicare claims. They are the basis for the correct coding edits that are installed in the claims processing systems effective January 1, 1996.

A. Coding Based On Standards Of Medical/Surgical Practice.-- All services integral to accomplishing a procedure are considered bundled into that procedure and, therefore, are considered a component part of the comprehensive code. Many of these generic activities are common to virtually all procedures

C. Therapy Assistants as Clinical Instructors.--Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors (CIs) for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

D. Services Provided Under Part A and Part B.--The payment methodologies for Part A and B therapy services rendered by a student are different. Under the physician fee schedule (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B. Under SNF PPS, payments are based upon the case mix or RUG category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determine the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

15350. DIALYSIS SERVICES (CODES 90935-90999)

A. ESRD Monthly Capitation Payments.--Effective January 1, 1995, monthly capitation payments are made under the physician fee schedule. For their adult patients, physicians may bill either the monthly code (CPT code 90921) or the daily code (CPT code 90925) with units that represent the number of days in a single month, but may not bill both.

To bill for a month of services for pediatric patients, providers should bill the appropriate monthly code (CPT codes 90918, 90919, or 90920). To bill for less than a month of service, providers bill the appropriate daily code (CPT codes 90922-90925) and units that represent the number of days. Providers may bill either the monthly code or the daily code, but not both. Since billing is done at the conclusion of the month, the patient's age at the end of month is the age of the patient for billing purposes.

B. Inpatient and Outpatient Dialysis Services On Same Date As An Evaluation and Management Service.--CPT codes 90935 and 90937 are used to report inpatient ESRD hemodialysis and outpatient hemodialysis performed on non-ESRD patients (e.g., patients in acute renal failure requiring a brief period of dialysis prior to recovery). CPT codes 90945 and 90947 are used to report all non-hemodialysis procedures. All four of these codes include payment for any evaluation and management services related to the patients renal disease that are provided on the same date as the dialysis service. Therefore, payment for all evaluation and management services is bundled into the payment for 90935, 90937, 90945, and 90947, except for the following evaluation and management services which may be reported on the same date as a dialysis service with the use of the --25 modifier and they are significant and separately identifiable and met any medical necessity requirements:

99201-99205	Office or Other Outpatient Visit for a New Patient
99211-99215	Office or Other Outpatient Visit for an Established Patient
99221-99223	Initial Hospital Care for a New or Established Patient
99238-99239	Hospital Discharge Day Management Services
99241-99245	Office or Other Outpatient Consultations, New or Established Patient
99251-99255	Initial Inpatient Consultations, New or Established Patient
99291-99292	Critical Care Services

In the absence of one of these codes being reported with the –25 modifier and meeting the other requirements listed above, pay only the dialysis service and deny the evaluation and management service. Furthermore, payment is not allowed for more than one dialysis service per day.

15360. ECHOCARDIOGRAPHY SERVICES (CODES 93303 - 93350)

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.

Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the carrier at the appropriate physician fee schedule amount based on the rendering UPIN/PIN.

"Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met (see §§2050.1, 2050.2 and 15501 Subsection G).

Office/Clinic Setting.--In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician's UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

Hospital Inpatient/Outpatient/Emergency Department Setting.--When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

Examples of Shared Visits:

1. If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.

2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's UPIN/PIN.

In the rare circumstance when a physician (or NPP) provides a service that does not reflect a CPT code description, the service must be reported as an unlisted service with CPT code 99499. A description of the service provided must accompany the claim. The carrier has the discretion to value the service when the service does not meet the full terms of a CPT code description (e.g., only a history is performed). The carrier also determines 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 non-physician 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.--Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) 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.