CMS Manual System

Pub. 100-20 One-Time Notification

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

Transmittal 34 **Date: DECEMBER 24, 2003**

CHANGE REQUEST 3028

I. SUMMARY OF CHANGES:
This notification provides revisions to the 2004 Physician Fee Schedule that will affect the amount physicians and other providers will receive when providing services to a Medicare beneficiary.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004
***IMPLEMENTATION DATE: January 5, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
	N/A

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**

***Medicare contractors only**

One Time Notification

Pub. 100-20	Transmittal: 34	Date: December 24, 2003	Change Request 3028

SUBJECT: 2004 Medicare Physician Fee Schedule ANNUAL CHANGES

I. GENERAL INFORMATION

Background: Effective January 1, 2004, new payment policies under the Medicare Physician Fee Schedule will be established for billing services.

B. Policy:

- The fee schedule update for 2004 is 1.5 percent. The conversion factor is $37.3374.

- The 2004 national average anesthesia conversion factor is $17.50.

- Section 1834(m) of the Social Security Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increased in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for 2004 is 2.9 percent. For calendar year 2004, the payment amount for HCPCS code "Q3014, telehealth originating site facility fee" is 80 percent of the lesser of the actual charge or $21.20.

- In those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time he/she is present with resident. The anesthesiologist can bill base units if he/she is present with the resident throughout pre-and post- anesthesia care. The anesthesiologist should use the "AA" modifier to report such cases. The teaching anesthesiologist must document his/her involvement in cases with residents. The documentation must be sufficient to support the payment of the fee and available for review upon request.

- For Independent Laboratory Billing for the Technical Component of Physician Pathology Services to Hospital Patients, section 542 of the Benefits and Improvement Act of 2000 provides that the Medicare carrier can continue to pay for the technical component (TC) of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital. This provision had applied to TC services furnished during the 2-year period beginning on January 1, 2001. Carriers shall continue to make payments in accordance with Transmittal B-03-001 issued in January, 2003 for 2004 and 2005.

- For Skin Lesions, Benign, and Malignant (CPT codes 11400 & 11600 series), we have withdrawn our proposal to make the work RVUs equivalent for removal of benign and malignant skin lesions in a budget neutral manner. We have decided to maintain the current values and request that the specialty societies resurvey the services.

- List of physicians who can enter into private contracts is expanded to include dentists, optometrists, and podiatrists. Previously, only physicians who were MDs and Doctors of Osteopathy could enter into private contracts with beneficiaries.

- For Intensity Modulated Radiation Therapy (IMRT), we will use the non-physician work pool methodology to establish final practice expense RVUs for 2004 that are approximately equal to the current ones.

- We will extend the deadline for submission of supplemental survey data for practice expense to March 1, 2004 to allow us to publish our decisions regarding survey data in the proposed rule to provide an opportunity for public comments. The laboratory community has submitted survey data that will be addressed in next year's Notice of Proposed Rulemaking (NPRM).

- There is a new definition of diabetes for diabetes self-management training (DSMT) at CFR 410.141 and medical nutritional therapy. In addition, the DSMT definition replaces the beneficiary's eligibility criteria in the old regulation.

- For dialysis patients seeing the doctor, we have created separate temporary codes that describe procedures or services, known as G codes, for 1 physician visit per month, 2-3 visits per month, and 4 or more visits per month, with payment increasing with the number of visits. The aggregate payments for these services are approximately equal to current payments for CPT codes 90918 to 90921.

  We also created new G codes for the management of home dialysis patients in each of the age groups. In addition, four new G codes for home dialysis patients who are hospitalized during the month were also created. These codes are to be used to report daily management of home dialysis patients for the days the patient was not in the hospital. We have provided a crosswalk from the current CPT codes to the G codes.

Patients Other than Home Dialysis

CPT Code	Age of Patient	New G Codes	Number of Visits
90918	< 2	G0308	4+
		G0309	2 to 3
		G0310	One visit
90919	2 to 11	G0311	4+
		G0312	2 to 3
		G0313	One visit

90920	12 to 19	G0314	4+
		G0315	2 to 3
		G0316	One visit
90921	20 +	G0317	4+
		G0318	2 to 3
		G0319	One visit

Home Dialysis Patients (entire month)

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No distinct CPT Codes	< 2	G0320
	2 – 11	G0321
	12 – 19	G0322
	20 +	G0323

Home Dialysis Patients (partial month only—perday)

90922	< 2	G0324
90923	2 – 11	G0325
90924	12-19	G0326
90925	20 +	G0327

- As in previous final rules, we have updated the list of certain services subject to the physician self-referral prohibition to address new and revised CPT and HCPCS codes.

- For chemotherapy administration, Section 303 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (DIMA) revises some of the Medicare physician payment policies for chemotherapy services.

    1. For chemotherapy services furnished prior to January 1, 2004, we allow CPT code 96408 (Chemotherapy administration, intravenous; push technique) to be reported only once per day even if the physician administers multiple drugs. For services furnished on or after January 1, 2004, we will allow code 96408 to be reported more than once per day for each drug administered.

    2. Section 303 of DIMA requires the Secretary to establish work relative value units for drug administration services equal to the work relative values for a level 1 office medical visit for an established patient (CPT code 99211). The law defines drug administration services as those services classified as of October 1, 2003, within any of the following groups: therapeutic or diagnostic infusions (excluding chemotherapy); chemotherapy administration services; and therapeutic, prophylactic, or diagnostic injections; for which there are no work relative values units assigned and for which national relative values are assigned. CPT code 99211 is a level 1 established patient office visit with

physician work relative value units of .17. We are adding physician work relative value units of .17 to the following drug administration services: CPT codes 90780-90781, 90782-90788, 96400, 96408-96425, 96520 and 96530.

3. For services furnished on or after January 1, 2004, we will not allow CPT code 99211 to be billed on the same day as a drug administration code that has a work relative value unit. We will continue to allow other office visits to be billed on the same day as a drug administration service with modifier 25 indicating that a separately identifiable evaluation and management service was provided.

4. We will revise the Internet Only Manual in 2004 to incorporate these revisions.

C. Provider Education: Carriers shall inform affected providers in the manner determined to be most appropriate.

Requirement #	Requirements	Responsibility
3028.1	**The Medicare contractor shall to pay anesthesia services according to the national average conversion factor of $17.50 for services rendered on and after January 1, 2004.**	Carrier
3028.2	**The Medicare contractor shall pay suppliers, physicians, and non physicians for services rendered on and after January 1, 2004 according to the conversion factor of 37.3374.**	Carrier
3028.3	**The Medicare contractor shall pay telehealth originating site fee of $21.20 for services rendered on and after 1/1/04**	Carrier/Intermed.

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions
3028.1	Continue use of AA modifier to identify teaching anesthesiologist.
3028.3	Telehealth fees for CY 2002--$20.00, for CY 2003--$20.60. $21.20 for 2004

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. OTHER CHANGES

Citation	Change	

V. SCHEDULE, CONTACTS, AND FUNDING

SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces:

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies:

F. Testing Considerations:

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2004 **Implementation Date: January 5, 2004** **Pre-Implementation Contact(s):Joan Mitchell** **Post-Implementation Contact(s):**	These instructions should be implemented within your current operating budget