

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev. 203, 06-10-04)

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10 - General

(Rev. 1, 10-01-03)

B3-2020

This chapter provides claims processing instructions for physician and nonphysician practitioner services.

Most physician services are paid according to the Medicare Physician Fee Schedule. Section 20 below offers additional information on the fee schedule application. Chapter 23 includes the fee schedule format and payment localities, and identifies services that are paid at reasonable charge rather than based on the fee schedule. In addition:

- Chapter 13 describes billing and payment for radiology services.
- Chapter 16 outlines billing and payment under the laboratory fee schedule.
- Chapter 17 provides a description of billing and payment for drugs.
- Chapter 18 describes billing and payment for preventive services and screening tests.

The Medicare Manual Pub 100-1, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, provides definitions for the following:

- Physician;
- Doctors of Medicine and Osteopathy;
- Dentists;
- Doctors of Podiatric Medicine;
- Optometrists;
- Chiropractors (but only for spinal manipulation); and
- Interns and Residents.

The Medicare Benefit Policy Manual, Chapter 15, provides coverage policy for the following services.

- Telephone services;
- Consultations;
- Patient initiated second opinions; and

- Concurrent care.

Chapter 26 provides guidance on completing and submitting Medicare claims.

20 - Medicare Physicians Fee Schedule (MPFS)

(Rev. 1, 10-01-03)

B3-15000

Carriers 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.

Chapter 23 provides a list of physicians' services payable based on the Medicare Physician Fee Schedule (MPFS).

20.1 - Method for Computing Fee Schedule Amount

(Rev. 1, 10-01-03)

B3-15006

The CMS continually updates, refines, and alters the methods used in computing the fee schedule amount. For example, input from the American Academy of Ophthalmology has led to alterations in the supplies and equipment used in the computation of the fee schedule for selected procedures. Likewise, new research has changed the payments made for physical and occupational therapy. The CMS provides the updated fee schedules to carriers on an annual basis. The sections below introduce the formulas used for fee schedule computations.

A - Formula

The fully implemented resource-based MPFS amount for a given service can be computed by using the formula below:

$$\text{MPFS Amount} = [(\text{RVU}_w \times \text{GPCI}_w) + (\text{RVU}_{pe} \times \text{GPCI}_{pe}) + (\text{RVU}_m \times \text{GPCI}_m)] \times \text{CF}$$

Where:

RVU_w equals a relative value for physician work,

RVU_{pe} equals a relative value for practice expense, and

RVU_m refers to a relative value for malpractice.

In order to consider geographic differences in each payment locality, three geographic practice cost indices (GPCIs) are included in the core formula:

- A GPCI for physician work (GPCI_w),
- A GPCI for practice expense (GPCI_{pe}), and
- A GPCI for malpractice (GPCI_m).

The above variables capture the efforts and productivity of the physician, his/her individualized costs for staff and for productivity-enhancing technology and materials. The applicable national conversion factor (CF) is then used in the computation of every MPFS amount.

The national conversion factors are:

- 2002 - \$36.1992
- 2001 - \$38.2581
- 2000 - \$36.6137
- 1999 - \$34.7315
- 1998 - \$36.6873
- 1997 - \$40.9603 (Surgical); \$33.8454 (Nonsurgical); \$35.7671 (Primary Care)
- 1996 - \$40.7986 (Surgical); \$34.6296 (Nonsurgical); \$35.4173 (Primary Care)
- 1995 - \$39.447 (Surgical); \$34.616 (Nonsurgical); \$36.382 (Primary Care)
- 1994 - \$35.158 (Surgical); \$32.905 (Nonsurgical); \$33.718 (Primary Care)
- 1993 - \$31.926 (Surgical); \$31,249 (Nonsurgical);
- 1992 - \$31.001

For the years 1999 through 2002, payments attributable to practice expenses transitioned from charge-based amounts to resource-based practice expense RVUs. The CMS used the following transition formula to calculate the practice expense RVUs.

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

2000 - 50 percent of the charge-based 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.

As the tabular display introduced earlier indicates, CMS has calculated separate facility and nonfacility resource-based practice expense RVUs.

B - Example of Computation of Fee Schedule Amount

The following example further clarifies the computation of a fee schedule amount.

Background Example

Nationwide, cardiovascular disease has retained its position as a primary cause of morbidity and mortality. Currently, cardiovascular disease affects approximately 61.8 million Americans. Cardiovascular disease is responsible for over 40 percent of all deaths in the United States. However, 84.3 percent of those deaths are persons age 65 and above.

Organ transplantation is one modality that has been used in the treatment of cardiovascular disease. Currently over 2,000 persons per year receive a heart transplant. However, another 2,300 persons are on the waiting list. Because of the disparity between the demand and supply of organs, mechanical heart valves are now covered under Medicare.

Sample Computation of Fee Schedule

Patients fitted with a mechanical heart valve require intensive home international normalized ratio (INR) monitoring by his/her physician. Physician services required may include instructions on demonstrations to the patient regarding the use and maintenance of the INR monitor, instructions regarding the use of a blood sample for reporting home INR test results, and full confirmation that the client can competently complete the required self-testing.

Assumptions

$$RVU_w = 0$$

Given the nature of the example, the physician would, under product code G0248, not be allowed to assign work RVUs.

$$RVU_m = .01$$

However, the treatment of the patient with a mechanical heart carries a level of risk.

$$RVU_{pe} = 2.92$$

Based upon a relatively intense level of staff time for an RN/LRN, or MN, as well as a supply list that includes a relatively sophisticated home INR monitor, batteries,

educational materials, test strips and other materials, the RVU_{pe} can be assigned a value of 2.92.

The above values require modification by regionally based values for work, practice, and malpractice. If the city is assumed to be Birmingham, Alabama, the values below can be assigned based upon current data.

$$\text{GPCI}_w = 0.994$$

$$\text{GPCI}_{pe} = 0.912$$

$$\text{GPCI}_m = 0.927$$

The above indices suggest that the index in Birmingham is .6 percent below the national norm for physician work intensity, 8.8 percent below the national norm for practice expenses, and 7.3 percent below the national norm for malpractice.

If the assumption is made that the nonfacility payment for a home visit is \$166.52, the full fee schedule payment can be computed through substitution into the formula.

$$\text{Payment} = (\text{RVU}_w \times \text{GPCI}_w + (\text{RVU}_{pe} \times \text{GPCI}_{pe}) + \text{RVU}_m + \text{GPCI}_m \times \text{physician fee schedule payment}.$$

$$\text{Payment} = (0 \times .994) + (2.92 \times .927) + (.01 \times .912) \times \$166.52 =$$

$$\text{Payment} = (0) + (2.70684) + (.00912) \times 166.52$$

$$\text{Payment} = \$452.26166 \text{ or } \$452.26 \text{ when rounded to the nearest cent.}$$

The above example is purely illustrative. The CMS completes all calculations and provides carriers with final fee schedules for each locality via the Medicare Physicians' Fee Schedule Database (MPFSDB). Localities used to pay services under the MPFS are listed in Chapter 23.

20.2 - Relative Value Units (RVUs)

(Rev. 1, 10-01-03)

Resource-based practice expenses relative value units (RVUs) comprise the core of physician fees paid under Medicare Part B payment policies. The CMS provides carriers with the fee schedule RVUs for all services except the following:

- Those with local codes;
- Those with national codes for which national relative values have not been established;
- Those requiring "By Report" payment or carrier pricing; and

- Those that are not included in the definition of physicians' services.

For services with national codes but for which national relative values have not been provided, carriers must establish local relative values (to be multiplied, in the carrier system, by the national CF), as appropriate, or establish a flat local payment amount. Carriers may choose between these options.

The "By Report" services (with national codes or modifiers) include services with codes ending in 99, team surgery services, unusual services, pricing of the technical component for positron emission tomography reduced services, and radio nuclide codes A4641 and 79900. The status indicators of the Medicare fee schedule database identify these specific national codes and modifiers that carriers are to continue to pay on a "By Report" basis. Carriers may not establish RVUs for them. Similarly, carriers may not establish RVUs for "By Report" services with local codes or modifiers.

Additionally, carriers do not establish fees for noncovered services or for services always bundled into another service. The MPFSDB identifies noncovered national codes and codes that are always bundled.

A - 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 CMS makes the determination of which HCPCS codes fall into this category.

B - No Special RVUs for Limited License Practitioners

There are no special RVUs for limited license physicians, e.g., optometrists and 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. Carriers may not restrict either physicians, independently practicing physical therapists, and/or other providers of covered services by the use of these codes.

20.3 - Bundled Services/Supplies

(Rev. 147, 04-23-04)

There are a number of services/supplies that are covered under Medicare and that have HCPCS codes, but they are services for which Medicare bundles payment into the payment for other related services. If carriers receive a claim that is solely for a service or supply that must be mandatorily bundled, the claim for payment should be denied by the carrier.

A - Routinely Bundled

Separate payment is never made for routinely bundled services and supplies. The CMS has provided RVUs for many of the bundled services/supplies. However, the RVUs are not for Medicare payment use. Carriers may not establish their own relative values for these services.

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. Carriers must pay separately for those injection services only if no other physician fee schedule service is being paid. In either case, the drug is separately payable. If, for example, code 99211 is billed with an injection service, pay only for code 99211 and the separately payable drug. (See section 30.6.7.D.) Injection services that are immunizations with hepatitis B, pneumococcal, and influenza vaccines are not included in the fee schedule and are paid under the drug pricing methodology as described in Chapter 17.

C - Global Surgical Packages

The MPFSDB lists the global charge period applicable to surgical procedures.

D - Intra-Operative and/or Duplicate Procedures

Chapter 23 and §30 of this chapter describe the correct coding initiative (CCI) and policies to detect improper coding and duplicate procedures.

E - EKG Interpretations

For services provided between January 1, 1992, and December 31, 1993, carriers must not make separate payment for EKG interpretations performed or ordered as part of, or in conjunction with, visit or consultation services. The EKG interpretation codes that are bundled in this way are 93000, 93010, 93040, and 93042. Virtually, all EKGs are performed as part of or ordered in conjunction with a visit, including a hospital visit.

If the global code is billed for, i.e., codes 93000 or 93040, carriers should assume that the EKG interpretation was performed or ordered as part of a visit or consultation. Therefore, they make separate payment for the tracing only portion of the service, i.e., code 93005 for 93000 and code 93041 for 93040. When the carrier makes this assumption in processing a claim, they include a message to that effect on the Medicare Summary Notice (MSN).

For services provided on or after January 1, 1994, carriers make separate payment for an EKG interpretation.

20.4 - Summary of Adjustments to Fee Schedule Computations

(Rev. 1, 10-01-03)

B3-15024

For services prior to January 1, 1994, carriers computed the fee schedule amount for every service. Through 1995, the fee schedule amount is the transition fee schedule amount. For services after 1995, CMS computes and provides the fee schedule amount for every service discussed above.

Certain adjustments are made in order to arrive at the final fee schedule amount.

Those adjustments are:

- Participating versus nonparticipating differential;
- Reduction for re-operations;
- Site of service payment adjustment;
- Multiple surgeries;
- Bilateral surgery;
- Purchased diagnostic services;
- Provider providing less than global fee package;
- Assistant at surgery;
- Two surgeons/surgical team; and
- Supplies.

20.4.1 - Participating Versus Nonparticipating Differential

(Rev. 1, 10-01-03)

B3-15032

For services/supplies rendered prior to January 1, 1994, the amounts allowed to nonparticipating physicians, under the fee schedule may not exceed 95 percent of the participating fee schedule amount. Payments to other entities under the fee schedule (physiological and independent laboratories, physical and occupational therapists, portable x-ray suppliers, etc.) are not subject to this differential unless the entities are billing for a physician's professional service. When a nonparticipating nonphysician is billing for a physician's professional service, Medicare's allowance could not exceed 95 percent of the fee schedule amount.

For services/supplies rendered on or **after January 1, 1994**, payments to **any** nonparticipant may not exceed 95 percent of the fee schedule amount **or** other payment basis for the service/supply. This five percent reduction applies not only to nonparticipating physicians, physician assistants, nurse midwives, and clinical nurse specialists but also to entities such as nonparticipating portable x-ray suppliers, independently practicing physical and occupational therapists, audiologists, and other diagnostic facilities. Furthermore, these nonparticipating entities including physicians, are subject to the five percent reduction not only when they bill for services paid for under the physician fee schedule, but also when they bill for services that are legally billable under the physician fee schedule, but which are based upon alternative payment methodologies. As of January 1, 1994 and beyond, the services/supplies included in this latter category are drugs and biologicals provided incident to physicians services. The payment basis for these drugs and biologicals is the lower of the average wholesale price (AWP) or the estimated acquisition cost (EAC). Therefore, the Medicare payment allowance for “incident to” drugs and biologicals billed by and a nonparticipant cannot exceed 95 percent of whichever is lower than the AWP or the EAC.

20.4.2 - Site of Service Payment Differential

(Rev. 1, 10-01-03)

B3- 5036

Under the physician fee schedule, some procedures have a separate Medicare fee schedule for a physician’s professional services when provided in a facility and a nonfacility. The CMS furnishes both fees in the MPFSDB update.

Professional fees, when the services are provided in a facility, are applicable to procedures furnished in the facilities. Site of service payment differentials also apply in an inpatient psychiatric facility and in a comprehensive inpatient rehabilitation facility.

Site of service payment differentials also apply in an inpatient psychiatric facility and in a comprehensive inpatient rehabilitation facility. Place of service code (POS) is used to identify where the procedure is furnished. In addition when the physician bills for a service performed in an ASC, the carrier must review the HCPCS code against the list of procedures approved for ASCs. The list of places of service subject to facility fees include:

- In hospitals (POS code 21-23);
- In skilled nursing facilities (SNF) for a Part A resident (POS code 31);
- In comprehensive inpatient rehabilitation facilities (POS 61);
- In inpatient psychiatric facilities (POS 51);
- In community mental health centers (CMHC) (POS code 53); and

- In an approved ambulatory surgical center (ASC) for a HCPCS code included on the ASC approved list of procedures - (POS code 24).

Nonfacility fees are applicable to procedures furnished:

- In SNFs to Part B residents - (POS code 32);
- In an ASC that is not approved for Medicare regardless of the procedure;
- In a Medicare approved ASC for a procedure not on the ASC list of approved procedures; and
- In all other facilities.

Nonfacility fees are applicable to therapy procedures regardless of whether they are furnished in facility or nonfacility settings.

20.4.3 - Assistant at Surgery Services

(Rev. 1, 10-01-03)

B3-15044

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

Carriers may not pay assistants at surgery for surgical procedures in which a physician is used as an assistant at surgery in fewer than five percent of the cases for that procedure nationally. This is determined through manual reviews.

In addition to the assistant at surgery modifiers “-80,” “-81,” or “-82,” any procedures submitted with modifier AS are subject to the assistant surgeon’s policy enunciated in the Medicare physician fee schedule database (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 assistant at surgery limit. Physicians who knowingly and willfully violate this prohibition and bill a beneficiary for an assistant at surgery service for these procedure codes may be subject to the penalties contained under §1842(j)(2) of the Social Security Act (the Act.) Penalties vary based on the frequency and seriousness of the violation.

20.4.4 - Supplies

(Rev. 1, 10-01-03)

B3-15900.2

Carriers make a separate payment for supplies furnished in connection with a procedure only when one of the two following conditions exists:

- A. HCPCS code A4300 is billed in conjunction with the appropriate procedure in the Medicare Physician Fee Schedule Data Base (place of service is physician's office). However, A4550, A4300, and A4263 are no longer separately payable as of 2002. Supplies have been incorporated into the practice expense RVU for 2002. Thus, no payment may be made for these supplies for services provided on or after January 1, 2002.
- B. The supply is a pharmaceutical or radiopharmaceutical diagnostic imaging agent (including codes A4641 through A4647); pharmacologic stressing agent (code J1245); or therapeutic radionuclide (CPT code 79900). Other agents may be used which do not have an assigned HCPCS code. The procedures performed are:
 - Diagnostic radiologic procedures (including diagnostic nuclear medicine) requiring pharmaceutical or radiopharmaceutical contrast media and/or pharmacologic stressing agent;
 - Other diagnostic tests requiring a pharmacologic stressing agent;
 - Clinical brachytherapy procedures (other than remote after-loading high intensity brachytherapy procedures (CPT codes 77781 through 77784) for which the expendable source is included in the TC RVUs); or
 - Therapeutic nuclear medicine procedures.

Drugs are not supplies, and may be paid incidental to physicians' services as described in Chapter 17.

20.4.5 - Allowable Adjustments

(Rev. 1, 10-01-03)

B3-15055

Effective January 1, 2000, the replacement code (CPT 69990) for modifier -20 - microsurgical techniques requiring the use of operating microscopes 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 64871

64885 through 64891

64905 through 64907.

20.4.6 - Payment Due to Unusual Circumstances (Modifiers “-22” and “-52”)

(Rev. 1, 10-01-03)

B3-15028

The fees for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. Thus, carriers may increase or decrease the payment for a service only under very unusual circumstances based upon review of medical records and other documentation.

20.5 - No Adjustments in Fee Schedule Amounts

(Rev. 1, 10-01-03)

B3-15054

Carriers may not make adjustments in fee schedule amounts provided by CMS for:

- Inherent reasonableness;
- Comparability;
- Multiple visits to nursing homes (i.e., when more than one patient is seen during the same trip);

- Refractions - If carriers receive a claim for a service that also indicates that a refraction was done, carriers do not reduce payment for the service. The CMS has already made the reduction in the fee for refractions provided to carriers;
- HCPCS alpha-numeric modifiers AT (acute treatment), ET (emergency treatment), LT (left side of body), RT (right side of body), and SF (second opinion ordered by PRO);
- 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).

20.6- Update Factor for Fee Schedule Services

(Rev. 1, 10-01-03)

B3-15058

The CMS provides updates to the MPFSDB annually. Carriers must maintain in the system at least two updates or payment periods for the MPFSDB, i.e. at least maintain in the system the current fee schedule screens and the prior year. After July 1, 2003, carriers must maintain a current pricing period and four prior pricing periods (five in total) for MPFS services.

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, carriers pay based on the prior year screen. Generally, physicians and suppliers are required to submit claims within 12 months of providing a service.

NOTE: Physicians and suppliers are subject to a 10 percent reduction if their claims are processed more than 12 months after the services are rendered, but carriers can process claims after those 12 months. Also, there are limited cases where extensions are granted to the time limit

20.7 - Comparability of Payment Provision of Delegation of Authority by CMS to Railroad Retirement Board

(Rev. 1, 10-01-03)

B3-15064

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 FI acting for 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.

30 - Correct Coding Policy

(Rev. 1, 10-01-03)

B3-15068

The Correct Coding Initiative was developed to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. Refer to Chapter 23 for additional information on the initiative.

The principles for the correct coding policy are:

- The service represents the standard of care in accomplishing the overall procedure;
- The service is necessary to successfully accomplish the comprehensive procedure. Failure to perform the service may compromise the success of the procedure; and
- The service does not represent a separately identifiable procedure unrelated to the comprehensive procedure planned.

For a detailed description of the correct coding policy, refer to <http://www.cms.hhs.gov/medlearn/ncci.asp>.

The CMS as well as many third party payers have adopted the HCPCS/CPT coding system for use by physicians and others to describe services rendered. The 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. For a list of CPT and HCPCS codes refer to the CMS Web site.

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 and, on other occasions, some are integral to only a certain group of procedures, but are still essential to accomplish these particular procedures. Accordingly, it is inappropriate to separately report these services based on standard medical and surgical principles.

Because many services are unique to individual CPT coding sections, the rationale for rebundling is described in that particular section of the detailed coding narratives that are transmitted to carriers periodically.

B - CPT Procedure Code Definition

The format of the CPT manual includes descriptions of procedures, which are, in order to conserve space, not listed in their entirety for all procedures. The partial description is indented under the main entry. The main entry then encompasses the portion of the description preceding the semicolon. The main entry applies to and is a part of all indented entries, which follow with their codes.

In the course of other procedure descriptions, the code definition specifies other procedures that are included in this comprehensive code. In addition, a code description may define a rebundling relationship where one code is a part of another based on the language used in the descriptor.

C - CPT Coding Manual Instruction/Guideline

Each of the six major subsections include guidelines that are unique to that section. These directions are not all inclusive of nor limited to, definitions of terms, modifiers, unlisted procedures or services, special or written reports, details about reporting separate, and multiple or starred procedures and qualifying circumstances.

D - Coding Services Supplemental to Principal Procedure (Add-On Codes) Code

Generally, these are identified with the statement “list separately in addition to code for primary procedure” in parentheses, and other times the supplemental code is used only with certain primary codes, which are parenthetically identified. The reason for these CPT codes is to enable physicians and others to separately identify a service that is performed in certain situations as an additional service. Incidental services that are necessary to accomplish the primary procedure (e.g., lysis of adhesions in the course of an open cholecystectomy) are not separately billed.

E - Separate Procedures

The narrative for many CPT codes includes a parenthetical statement that the procedure represents a “separate procedure.”

The inclusion of this statement indicates that the procedure, while possible to perform separately, is generally included in a more comprehensive procedure, and the service is not to be billed when a related, more comprehensive, service is performed. The “separate procedure” designation is used with codes in the surgery (CPT codes 10000-69999), radiology (CPT codes 70000-79999), and medicine (CPT codes 90000-99199) sections. When a related procedure from the same section, subsection, category, or subcategory is performed, a code with the designation of “separate procedure” is not to be billed with the primary procedure.

F - Designation of Sex

Many procedure codes have a sex designation within their narrative. These codes are not billed with codes having an opposite sex designation because this would reflect a conflict in sex classification either by the definition of the code descriptions themselves, or by the fact that the performance of these procedures on the same beneficiary would be anatomically impossible.

G - Family of Codes

In a family of codes, there are two or more component codes that are not billed separately because they are included in a more comprehensive code as members of the code family. Comprehensive codes include certain services that are separately identifiable by other component codes. The component codes as members of the comprehensive code family represent parts of the procedure that should not be listed separately when the complete procedure is done. However, the component codes are considered individually if performed independently of the complete procedure and if not all the services listed in the comprehensive codes were rendered to make up the total service.

H - Most Extensive Procedures

When procedures are performed together that are basically the same or performed on the same site but are qualified by an increased level of complexity, the less extensive procedure is bundled into the more extensive procedure.

I - Sequential Procedures

An initial approach to a procedure may be followed at the same encounter by a second, usually more invasive approach. There may be separate CPT codes describing each service. The second procedure is usually performed because the initial approach was unsuccessful in accomplishing the medically necessary service. These procedures are considered “sequential procedures.” Only the CPT code for one of the services, generally the more invasive service, should be billed.

J - With/Without Procedures

In the CPT manual, there are various procedures that have been separated into two codes with the definitional difference being “with” versus “without” (e.g., with and without

contrast). Both procedure codes cannot be billed. When done together, the “without” procedure is bundled into the “with” procedure.

K - Laboratory Panels

When components of a specific organ or disease oriented laboratory panel (e.g., codes 80061 and 80059) or automated multi-channel tests (e.g., codes 80002 - 80019) are billed separately, they must be bundled into the comprehensive panel or automated multi-channel test code as appropriate that includes the multiple component tests. The individual tests that make up a panel or can be performed on an automated multi-channel test analyzer are not to be separately billed.

L - Mutually Exclusive Procedures

There are numerous procedure codes that are not billed together because they are mutually exclusive of each other. Mutually exclusive codes are those codes that cannot reasonably be done in the same session.

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 - 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 code modifier. Such modifiers are modifiers E1 - E4, FA, F1 - F9, TA, T1 - T9, LT, RT, LC, LD, RC, -58, -78, -79, and -94.

Modifier -59 is not appropriate to use with weekly radiation therapy management codes (77427) or 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.

30.1 - Digestive System (Codes 40000 - 49999)

(Rev. 1, 10-01-03)

B3-15100

A - Upper Gastrointestinal Endoscopy Including Endoscopic Ultrasound (EUS) (Code 43259)

If the person performing the original diagnostic endoscopy has access to the EUS and the clinical situation requires an EUS, the EUS may be done at the same time. The procedure, diagnostic and EUS, is reported under the same code, CPT 43259. This code conforms to CPT guidelines for the indented codes. The service represented by the indented code, in this case code 43259 for EUS, includes the service represented by the unintended code preceding the list of indented codes. Therefore, when a diagnostic examination of the upper gastrointestinal tract “including esophagus, stomach, and either the duodenum or jejunum as appropriate,” includes the use of endoscopic ultrasonography, the service is reported by a single code, namely 43259.

Interpretation, whether by a radiologist or endoscopist, is reported under CPT code 76975-26. These codes may both be reported on the same day.

B - Incomplete Colonoscopies (Codes 45330 and 45378)

An incomplete colonoscopy, e.g., the inability to extend beyond the splenic flexure, is billed and paid using colonoscopy code 45378 with modifier “-53.” The Medicare physician fee schedule database has specific values for code 45378-53. These values are the same as for code 45330, sigmoidoscopy, as failure to extend beyond the splenic flexure means that a sigmoidoscopy rather than a colonoscopy has been performed. However, code 45378-53 should be used when an incomplete colonoscopy has been done because other MPFSDB indicators are different for codes 45378 and 45330.

30.2 - Urinary and Male Genital Systems (Codes 50010 - 55899)

(Rev. 1, 10-01-03)

B3-15200

A - Cystourethroscopy With Ureteral Catheterization (Code 52005)

Code 52005 has a zero in the bilateral field (payment adjustment for bilateral procedure does not apply) because the basic procedure is an examination of the bladder and urethra (cystourethroscopy), which are not paired organs. The work RVUs assigned take into account that it may be necessary to examine and catheterize one or both ureters. No additional payment is made when the procedure is billed with bilateral modifier “-50.” Neither is any additional payment made when both ureters are examined and code 52005 is billed with multiple surgery modifier “-51.” It is inappropriate to bill code 52005 twice, once by itself and once with modifier “-51,” when both ureters are examined.

B - Cystourethroscopy With Fulgration and/or Resection of Tumors (Codes 52234, 52235, and 52240)

The descriptors for codes 52234 through 52240 include the language “tumor(s).”

This means that regardless of the number of tumors removed, only one unit of a single code can be billed on a given date of service. It is inconsistent to allow payment for removal of a small (code 52234) and a large (code 52240) tumor using two codes when only one code is allowed for the removal of more than one large tumor. For these three codes only one unit may be billed for any of these codes, only one of the codes may be billed, and the billed code reflects the size of the largest tumor removed.

30.3 - Otolaryngology and Audiology/Speech/Language Tests and Treatments (Codes V5299, V5362 - V5364, 69000 - 69979, and 92502 - 92599)

(Rev. 1, 10-01-03)

B3-15300

A - Cochlear Implant “Tune Up” Not In Global Surgical Fee

Payment for cochlear rehabilitation services following cochlear implantation surgery is not included in the global fee for the surgery. When these services are provided by an employee of a physician (typically an audiologist), and the requirements for coverage as “incident to a physician’s service” are met, for services rendered prior to January 1, 1996, the physician bills for the services using CPT code 69949; and carriers pay for the service on a “by report” basis. For services rendered on or after January 1, 1996, new CPT code 92510 is used and carriers make payment based on the fee schedule amount for code 92510.

B - Evaluation/Treatment of Speech, Language, Voice, Communication, and/or Auditory Processing, Including Evaluating Aural Rehabilitation Status or Providing Aural Rehabilitation Services

Codes 92506, 92507, and 92508 are used to report a single encounter with “1” as the unit of service, regardless of the duration of the service on a given day. Note that this is one unit per encounter, not per 15 minutes, 30 minutes, etc.

30.4 - Echocardiography Services (Codes 93303 - 93350)

(Rev. 1, 10-01-03)

B3-15360

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.

30.5 - Chemotherapy Administration (Codes 96400 - 96549) And Non Chemotherapy Drug Infusions (Codes 90780-90781)

(Rev. 147, 04-23-04)

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 anti-neoplastic **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 anti-neoplastics to patients with a diagnosis other than cancer, are reported with codes 90780 through 90784 as appropriate. For services furnished on or after January, 1, 2004, do not allow payment for CPT code 99211, with or without modifier 25, if it is billed with a nonchemotherapy drug infusion code, 90780 or 90781, or a chemotherapy administration code, 96400, 96408 to 96425, 96520, or 96530.

Physicians providing chemotherapy drug administration services (or nonchemotherapy drug infusion services) and evaluation and management services, other than CPT code 99211, on the same day must bill in accordance with section 30.6.6 using modifier "25". Carriers pay for evaluation and management services provided on the same day as the chemotherapy drug administration (or nonchemotherapy drug infusion services) if the evaluation and management service meets the requirements of section 30.6.6 even though the underlying codes do not have global periods.

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. Only one push administration is paid on a single day. For services furnished on or after January 1, 2004, allow code 96408 to be reported and paid once per day for each drug administered.

C - Chemotherapy Infusion and Hydration Therapy Infusion on Same Day

Separate payment is not allowed for the infusion of saline, an anti-emetic, 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 "-59" to indicate when CPT codes 90780 and 90781 are provided sequentially with CPT codes 96410, 96412, and 96414.

D - 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.

30.6 - Evaluation and Management Service Codes - General (Codes 99201 - 99499)

(Rev. 178, 05-14-04)

B3-15501-15501.1

30.6.1 - Selection of Level of Evaluation and Management Service

(Rev. 178, 05-14-04)

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 (refer to sections 60.1, 60.2, and 60.3, chapter 15 in IOM 100-02).

SPLIT/SHARED E/M SERVICE

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.

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient's care after the

patient has left the office or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

D - Use of Highest Levels of Evaluation and Management Codes

Carriers must advise physicians that to bill the highest levels of visit and consultation codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT's definition of a comprehensive history).

The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient's medical, family, and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.

The comprehensive examination may be a complete single system exam such as cardiac, respiratory, psychiatric, or a complete multi-system examination.

30.6.2 - Billing for Medically Necessary Visit on Same Occasion as Preventive Medicine Service

(Rev. 1, 10-01-03)

See Chapter 18 for payment for covered preventive services.

When a physician furnishes a Medicare beneficiary a covered visit at the same place and on the same occasion as a noncovered preventive medicine service (CPT codes 99381-99397), consider the covered visit to be provided in lieu of a part of the preventive medicine service of equal value to the visit. A preventive medicine service (CPT codes 99381-99397) is a noncovered service. The physician may charge the beneficiary, as a charge for the noncovered remainder of the service, the amount by which the physician's current established charge for the preventive medicine service exceeds his/her current established charge for the covered visit. Pay for the covered visit based on the lesser of the fee schedule amount or the physician's actual charge for the visit. The physician is not required to give the beneficiary written advance notice of noncoverage of the part of the visit that constitutes a routine preventive visit. However, the physician is responsible for notifying the patient in advance of his/her liability for the charges for services that are not medically necessary to treat the illness or injury.

There could be covered and noncovered procedures performed during this encounter (e.g., screening x-ray, EKG, lab tests.). These are considered individually. Those procedures which are for screening for asymptomatic conditions are considered noncovered and, therefore, no payment is made. Those procedures ordered to diagnose or monitor a symptom, medical condition, or treatment are evaluated for medical necessity and, if covered, are paid.

30.6.3 - Payment for Immunosuppressive Therapy Management

(Rev. 1, 10-01-03)

B3-4820-4824

Physicians bill for management of immunosuppressive therapy using the office or subsequent hospital visit codes that describe the services furnished. If the physician who is managing the immunotherapy is also the transplant surgeon, he or she bills these visits with modifier “-24” indicating that the visit during the global period is not related to the original procedure if the physician also performed the transplant surgery and submits documentation that shows that the visit is for immunosuppressive therapy.

30.6.4 - Evaluation and Management (E/M) Services Furnished Incident to Physician’s Service by Nonphysician Practitioners

(Rev. 1, 10-01-03)

When evaluation and management services are furnished incident to a physician’s service by a nonphysician practitioner, the physician may bill the CPT code that describes the evaluation and management service furnished.

When evaluation and management services are furnished incident to a physician’s service by a nonphysician employee of the physician, not as part of a physician service, the physician bills code 99211 for the service.

A physician is not precluded from billing under the “incident to” provision for services provided by employees whose services cannot be paid for directly under the Medicare program. Employees of the physician may provide services incident to the physician’s service, but the physician alone is permitted to bill Medicare.

Services provided by employees as “incident to” are covered when they meet all the requirements for incident to and are medically necessary for the individual needs of the patient.

30.6.5 - Physicians in Group Practice

(Rev. 1, 10-01-03)

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group.

30.6.6 - Payment for Evaluation and Management Services Provided During Global Period of Surgery

(Rev. 1, 10-01-03)

B3-4820-4824

A - CPT Modifier “-24” - Unrelated Evaluation and Management Service by Same Physician During Postoperative Period

Carriers pay for an evaluation and management service other than inpatient hospital care before discharge from the hospital following surgery (CPT codes 99221-99238) if it was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with CPT modifier “-24,” and accompanied by documentation that supports that the service is not related to the postoperative care of the procedure. They do not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred unless the doctor is also treating another medical condition that is unrelated to the surgery. All care provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment.

B - CPT Modifier “-25” - Significant Evaluation and Management Service by Same Physician on Date of Global Procedure

Carriers pay for an evaluation and management service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable evaluation and management service that is above and beyond the pre- and postoperative work of the procedure.

If the physician bills the service with the CPT modifier “-25,” carriers pay for the service in addition to the global fee without any other requirement for documentation unless one of the following conditions is met:

- When inpatient dialysis services are billed (CPT codes 90935, 90945, 90947, and 93937), the physician must document that the service was unrelated to the dialysis and could not be performed during the dialysis procedure;
- When preoperative 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; 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 prepayment screens or documentation requirements for that provider or group. When a carrier has completed a review and determined that a high usage rate of modifier “-57,” the carrier must complete a case-by-case review of the records. Based upon this review, the carrier will educate providers regarding the appropriate use of modifier “-57.” If high usage rates continue, the carrier may impose prepayment screens or documentation requirements for that provider or group.

Carriers may 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

Carriers 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 resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier “-57” if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.

30.6.7 - Payment for Office/Outpatient Visits (Codes 99201 - 99215)

(Rev. 1, 10-01-03)

B3-15502

A - Definition of New Patient for Selection of Visit Code

Carriers must interpret the phrase “new patient” to mean a patient who has not received any professional services from the physician **or physician group practice** within the previous three years.

If no evaluation and management service is performed, the patient may continue to be treated as a new patient. 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 and no evaluation and management service is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an evaluation and management service does not affect the designation of a new patient.

B - Office/Outpatient Visits Provided on Same Day for Unrelated Problems

Carriers may 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 five 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

Carriers may not pay a physician for an emergency department visit or an office visit **and** a comprehensive nursing facility assessment on the same day. They 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.

D - Injection and Evaluation and Management Code Billed Separately on Same Day of Service

Carriers must 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. Carriers may 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.

30.6.8 - Payment for Hospital Observation Services (Codes 99217 - 99220)

(Rev. 1, 10-01-03)

B3-15504

A - Who May Bill Initial Observation Care

Carriers 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, 99234, 99235, 99236) services unless the criteria for use of CPT modifiers “-24,” “-25,” or “-57” are met. Carriers must pay for these services in addition to the global surgical fee only if both of the following requirements are met:

- The hospital observation service meets the criteria needed to justify billing it with CPT modifiers “-24,” “-25,” or “-57” (decision for major surgery); and
- The hospital observation service furnished by the surgeon meets all of the criteria for the hospital observation code billed.

Examples of the decision for surgery during a hospital observation period are:

- A patient is admitted by an emergency department physician to an observation unit for observation of a head injury. A neurosurgeon is called in to do a consultation on the need for surgery while the patient is in the observation unit and decides that the patient requires surgery. The surgeon would bill an outpatient consultation with the “-57” modifier to indicate that the decision for surgery was made during the consultation. The surgeon must bill an outpatient consultation because the patient in an observation unit is not an inpatient of the hospital. Only the physician who admitted the patient to hospital observation may bill for initial observation care.
- A patient is admitted by a neurosurgeon to a hospital observation unit for observation of a head injury. During the observation period, the surgeon makes the decision for surgery. The surgeon would bill the appropriate level of hospital observation code with the “-57” modifier to indicate that the decision for surgery was made while the surgeon was providing hospital observation care.

Examples of hospital observation services during the postoperative period of a surgery are:

- A patient at the 80th day following a TURP is admitted to observation by the surgeon who performed the procedure with abdominal pain from a kidney stone. The surgeon decides that the patient does not require surgery. The surgeon would bill the observation code with CPT modifier “-24” and documentation to support that the observation services are unrelated to the surgery.
- A patient at the 80th day following a TURP is admitted to observation with abdominal pain by the surgeon who performed the procedure. While the patient is in hospital observation, the surgeon decides that the patient requires kidney surgery. The surgeon would bill the observation code with HCPCS modifier “-57” to indicate that the decision for surgery was made while the patient was in hospital observation. The subsequent surgical procedure would be reported with modifier “-79.”
- A patient at the 20th day following a resection of the colon is admitted to observation for abdominal pain by the surgeon who performed the surgery. The surgeon determines that the patient requires no further colon surgery and discharges the patient. The surgeon may not bill for the observation services furnished during the global period because they were related to the previous surgery.

An example of a billable hospital observation service on the same day as a procedure is a patient is admitted to the hospital observation unit for observation of a head injury by a physician who repaired a laceration of the scalp in the emergency department. The physician would bill the observation code with a CPT modifier 25 and the procedure code.

30.6.9 - Payment for Inpatient Hospital Visits - General (Codes 99221 - 99239)

(Rev. 1, 10-01-03)

B3-15505-15505.2

A - Hospital Visit and Critical Care on Same Day

See §30.6.12.E for billing of critical care on the day of another evaluation and management service.

B - Two Hospital Visits Same Day

Carriers pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not. The inpatient hospital visit descriptors contain the phrase “per day” which means that the code and the payment

established for the code represent all services provided on that date. The physician should select a code that reflects all services provided during the date of the service.

C - Hospital Visits Same Day But by Different Physicians

In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, carriers do not pay physician B for the second visit. The hospital visit descriptors include the phrase “per day” meaning care for the day.

If the physicians are each responsible for a different aspect of the patient’s care, pay both visits if the physicians are in different specialties and the visits are billed with different diagnoses. There are circumstances where concurrent care may be billed by physicians of the same specialty.

D - Visits to Patients in Swing Beds

If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply.

30.6.9.1 - Payment for Initial Hospital Care Services (Codes 99221 - 99223)

(Rev. 1, 10-01-03)

A - Initial Hospital Care From Emergency Room

Carriers pay for an initial hospital care service or an initial inpatient consultation if a physician sees his/her patient in the emergency room and decides to admit the person to the hospital. They do not pay for both E/M services. Also, they do not pay for an emergency department visit by the same physician on the same date of service. When the patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician’s office, nursing facility), all services provided by the physician in conjunction with that admission are considered part of the initial hospital care when performed on the **same date** as the admission.

B - Initial Hospital Care on Day Following Visit

Carriers pay both visits if a patient is seen in the office on one date and admitted to the hospital on the next date, even if fewer than 24 hours has elapsed between the visit and the admission.

C - Initial Hospital Care and Discharge on Same Day

Carriers pay only the initial hospital care code when a patient is admitted as an inpatient and discharged on the same day. They do not pay the hospital discharge management code on the date of admission. Carriers must instruct physicians that they may not bill

for both an initial hospital care code and hospital discharge management code on the same date.

D - Physician Services Involving Transfer From One Hospital to Another; 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

Physicians 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

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 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. Carriers 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

Physicians 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.

Carriers 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. Physicians that participate in the care of a patient but are not the admitting physician of record 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.

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

(Rev. 1, 10-01-03)

Carriers should follow the guidelines in the subsections below.

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). Carriers 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

Carriers 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 postoperative period of a service with the global surgical period, he/she bills for the nursing facility admission and care with a modifier “-24” 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 five years following discharge from the hospital for cholecystectomy).

Carriers 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.

30.6.10 - Consultations (Codes 99241 - 99275)

(Rev. 1, 10-01-03)

B3-15506

A - Consultation Versus Visit

Carriers pay for a consultation when all of the criteria for the use of a consultation code are met:

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

Carriers must 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 three 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

Carriers 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.

Limited licensed practitioners, e.g., nurse practitioners or physician assistants, may request a consultation. They may perform other services within the scope of practice for limited licensed practitioners 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 of a plan written in the requesting physician's progress note, an order in the medical record, or a specific written request for the consultation. In these settings, the report may consist of an appropriate entry in the common medical record. In an office setting, the documentation requirement may be met by a specific written request for the consultation from the requesting physician or if the consultant's records show a specific reference to the request. In this setting, the consultation report is a separate document communicated to the requesting physician.

E - Consultation for Preoperative Clearance

Preoperative consultations are payable for new or established patients performed by any physician at the request of a surgeon, as long as all of the requirements for billing the consultation codes are met.

F - Postoperative Care by Physician Who Did Preoperative Clearance Consultation

If subsequent to the completion of a preoperative consultation in the office or hospital, the consultant assumes responsibility for the management of a portion or all of the patient's condition(s) during the postoperative period, the consultation codes should not be used. In the hospital setting, the physician who has performed a preoperative consultation and assumes responsibility for the management of a portion or all of the patient's condition(s) during the postoperative period should use the appropriate subsequent hospital care codes (not follow-up consultation codes) to bill for the concurrent care he or she is providing. In the office setting, the appropriate established patient visit code should be used during the postoperative period.

A physician (primary care or specialist) who performs a postoperative evaluation of a new or established patient at the request of the surgeon may bill the appropriate consultation code for evaluation and management services furnished during the postoperative period following surgery as long as all of the criteria for the use of the consultation codes are met and that same physician has not already performed a preoperative consultation.

G - Surgeon's Request That Another Physician Participate In Postoperative Care

If the surgeon asks a physician who had not seen the patient for a preoperative consultation to take responsibility for the management of an aspect of the patient's condition during the postoperative period, the physician may not bill a consultation because the surgeon is not asking the physician's opinion or advice for the surgeon's use in treating the patient. The physician's services would constitute concurrent care and should be billed using the appropriate level visit codes.

H - Examples of Consultations

EXAMPLE 1

An internist sees a patient that he has followed for 20 years for mild hypertension and diabetes mellitus. The patient exhibits a new skin lesion and the internist sends the patient to a dermatologist for further evaluation. The dermatologist examines the patient and removes the lesion which is determined to be an early melanoma. The dermatologist dictates and forwards a report to the internist regarding his evaluation and treatment of the patient.

EXAMPLE 2

A general ophthalmologist diagnoses a patient with a retinal detachment. He sends the patient to a retinal subspecialist to evaluate the patient because the general ophthalmologist does not treat this specific problem. The retinal subspecialist evaluates the patient and subsequently schedules surgery. He sends a report to the referring physician explaining his findings and the treatment option selected.

EXAMPLE 3

A family physician diagnoses a patient with diabetes mellitus. The family physician asks the ophthalmologist for a base line evaluation to rule out diabetic retinopathy. The ophthalmologist examines the patient and sends a report to the family physician on his findings. The ophthalmologist tells the patient at the time of service to return in one year for a follow-up visit. This subsequent follow-up visit should be billed as an established patient visit in the office or other outpatient setting, as appropriate.

EXAMPLE 4

A rural family practice physician examines a patient who has been under his care for 20 years and diagnoses a new onset of atrial fibrillation. The family practitioner sends the patient to a cardiologist at an urban cardiology center for advice on his care and management. The cardiologist examines the patient, suggests a cardiac catheterization and other diagnostic tests which he schedules and then sends a written report to the requesting physician. The cardiologist subsequently routinely sees the patient once a year as follow-up. Subsequent visits provided by the cardiologist should be billed as an established patient visit in the office or other outpatient setting, as appropriate. Other routine care continues to be followed by the family practice physician.

EXAMPLE 5

A family practice physician examines a female patient who has been under his care for some time and diagnoses a breast mass. The family practitioner sends the patient to a general surgeon for advice and management of the mass and related patient care. The general surgeon examines the patient and recommends a breast biopsy, which he schedules, and then sends a written report to the requesting physician. The general surgeon subsequently performs a biopsy and then routinely sees the patient once a year as follow-up. Subsequent visits provided by the surgeon should be billed as an established patient visit in the office or other outpatient setting, as appropriate. Other routine care continues to be followed by the family practice physician.

EXAMPLE 6

An internist examines a patient who has been under his care for some time, and diagnoses a thyroid mass. The internist sends the patient to a general surgeon for advice on management of the mass and related patient care. The general surgeon examines the patient, orders diagnostic tests, and suggests a needle biopsy of the mass. The surgeon then schedules the procedure and sends a written report to the requesting physician. The general surgeon subsequently performs a thin needle biopsy and then routinely sees the patient twice as follow-up for the mass. Subsequent visits provided by the surgeon should be billed as an established patient visit in the office or other outpatient setting, as appropriate. Other routine care continues to be followed by the internist.

EXAMPLE 7

A patient with underlying diabetes mellitus and renal insufficiency is seen in the emergency room for the evaluation of fever, cough and purulent sputum. Since it is not clear whether the patient needs to be admitted, the emergency room physician requests an opinion by the on-call internist. The internist may bill a consultation regardless if the patient is discharged from the emergency room or whether the patient is admitted to the hospital as long as the criteria for consultation have been met. If the internist admits the patient to the hospital, he/she may bill either an initial inpatient consultation or initial hospital care code but not both for the same date of service.

I - Examples That Do Not Satisfy the Criteria for Consultations

EXAMPLE 1: Standing orders in the medical record for consultations.

EXAMPLE 2: No order for a consultation.

EXAMPLE 3: No written report of a consultation.

EXAMPLE 4: After hours, an internist receives a call from her patient about a complaint of abdominal pain. The internist believes this requires immediate evaluation and advises the patient to go to the emergency room where she meets the patient and evaluates him. The emergency room physician does not see the patient. The internist

should bill for the appropriate level of emergency department service, or if the patient is admitted to the hospital she would bill this visit as an inpatient admission.

30.6.11 - Emergency Department Visits (Codes 99281 - 99288)

(Rev. 1, 10-01-03)

B3-15507

A - Use of Emergency Department Codes by Physicians Not Assigned to Emergency Department

Any physician seeing a patient registered in the emergency department may use emergency department visit codes (for services matching the code description). It is not required that the physician be assigned to the emergency department.

B - Use of Emergency Department Codes In Office

Emergency department coding is not appropriate if the site of service is an office or outpatient setting or any sight of service other than an emergency department. The emergency department codes should only be used if the patient is seen in the emergency department and the services described by the HCPCS code definition are provided. The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.

C - Use of Emergency Department Codes to Bill Nonemergency Services

Services in the emergency department may not be emergencies. However the codes (99281 - 99288) are payable if the described services are provided.

However, if the physician asks the patient to meet him or her in the emergency department as an alternative to the physician's office and the patient is not registered as a patient in the emergency department, the physician should bill the appropriate office/outpatient visit codes. Normally a lower level emergency department code would be reported for a nonemergency condition.

D - Emergency Department or Office/Outpatient Visits on Same Day As Nursing Facility Admission

Emergency department visit provided on the same day as a comprehensive nursing facility assessment are not paid. Payment for evaluation and management services on the same date provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date as the nursing facility admission.

E - Physician Billing for Emergency Department Services Provided to Patient by Both Patient's Personal Physician and Emergency Department Physician

If a physician advises his/her own patient to go to an emergency department (ED) of a hospital for care and the physician subsequently is asked by the ED physician to come to the hospital to evaluate the patient and to advise the ED physician as to whether the patient should be admitted to the hospital or be sent home, the physicians should bill as follows:

- If the patient is admitted to the hospital by the patient's personal physician, then the patient's regular physician should bill only the appropriate level of the initial hospital care (codes 99221 - 99223) because all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The ED physician who saw the patient in the emergency department should bill the appropriate level of the ED codes.
- If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. The patient's personal physician would not bill a consultation because he or she is not providing information to the emergency department physician for his or her use in treating the patient. If the patient's personal physician does not come to the hospital to see the patient, but only advises the emergency department physician by telephone, then the patient's personal physician may not bill.

F - Emergency Department Physician Requests Another Physician to See the Patient in Emergency Department or Office/Outpatient Setting

If the emergency department physician requests that another physician evaluate a given patient, the other physician should bill a consultation if the criteria for consultation are met. If the criteria for a consultation are not met and the patient is discharged from the Emergency Department or admitted to the hospital by another physician, the physician contacted by the Emergency Department physician should bill an emergency department visit. If the consulted physician admits the patient to the hospital and the criteria for a consultation are not met, he/she should bill an initial hospital care code.

30.6.12 - Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

(Rev. 1, 10-01-03)

B3-15508

A - Use of Critical Care (Code 99292) in Cases Which are Not Medical Emergencies

Critical care includes the care of critically ill and unstable patients who require constant physician attention, whether the patient is in the course of a medical emergency or not. It involves decision making of high complexity to assess, manipulate, and support circulatory, respiratory, central nervous, metabolic, or other vital system function to prevent or treat single or multiple vital organ system failure. It often also requires extensive interpretation of multiple databases and the application of advanced technology to manage the critically ill patient.

Critical care is usually, but not always, given in a critical care area such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care. Services for a patient who is not critically ill and unstable but who happens to be in a critical care, intensive care, or other specialized care unit are reported using subsequent hospital care codes (99231-99233) or hospital consultation codes (99251 - 99263). Critical care may include neonatal intensive care.

B - Constant Attendance or Constant Attention as Prerequisite for Use of Critical Care Codes

The duration of critical care time to be reported is the time the physician spent working on the critical care patient's case, whether that time was spent at the immediate bedside or elsewhere on the floor, but immediately available to the patient.

For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be reported as critical care, even if it does not occur at the bedside.

Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient. This work is the typical pre and post-service work that accompanies any evaluation and management service. Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit at a patient's bedside (e.g., telephone calls to discuss other patients, reviewing literature).

For critical care to be billed, the physician must devote his or her full attention to the patient and, therefore, cannot render evaluation and management services to any other patient during the same period of time.

The time spent with the individual patient and the service rendered should be recorded in the patient's record to support the claim for critical care services.

C - Hours and Days of Critical Care

Payment for critical care is not restricted to a fixed number of days. As long as the critical care criteria are met and the services are reasonable and necessary to treat illness or injury, payment for critical care services is appropriate. However, claims for seemingly improbable amounts of critical care on the same date are subjected to review to determine if the physician has filed a false claim.

D - Counting of Units of Critical Care Services

Code 99291 (critical care, first hour) is used to report the services of a physician providing constant attention to a critically ill patient for a total of 30 to 74 minutes on a given day. Only one unit of code 99291 may be billed by a physician for a patient on a given date.

If the total duration of critical care provided by the physician on a given day is less than 30 minutes, the appropriate evaluation and management code should be used. In the hospital setting, it is expected that the Level 3 subsequent hospital care code 99233 would most often be used.

Code 99292 (critical care, each additional 30 minutes) is used to report the services of a physician providing constant attention to the critically ill patient for 15 to 30 minutes beyond the first 74 minutes of critical care on a given day.

The following illustrates the correct reporting of critical care services:

Total Duration of Critical Care	Code(s)
Less than 30 minutes	99232 or 99233
30-74 minutes	99291 x 1
75-104 minutes	99291 x 1 and 99292 x 1
105-134 minutes	99291 x 1 and 99292 x 2
135-164 minutes	99291 x 1 and 99292 x 3
165-194 minutes	99291 x 1 and 99292 x 4

E - Critical Care Service and other Evaluation and Management Services Provided on Same Day

If critical care is required upon the patient's presentation to the emergency department, only critical care codes 99291-99292 may be reported. Emergency department codes will not be paid for the same day. If there is a hospital or office/outpatient evaluation and management service furnished early in the day and at that time the patient does not require critical care, but the patient requires critical care later in the day, both critical care and the evaluation and management service may be paid.

Physicians must submit supporting documentation when critical care is billed on the same day as other evaluation and management services.

F - Critical Care Services Provided During Preoperative Portion of Global Period of Procedure With 90 Day Global Period in Trauma and Burn Cases

Preoperative critical care may be paid in addition to a global fee if the patient is critically ill and requires the constant attendance of the physician, **and** the critical care is unrelated to the specific anatomic injury or general surgical procedure performed. Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met. Codes 99291/99292 **and** modifier "-25" (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

G - Critical Care Services Provided During Postoperative Period of Procedure With Global Period in Trauma and Burn Cases

Postoperative critical care may be paid in addition to a global fee if the patient is critically ill and requires the constant attendance of the physician, **and** the critical care is unrelated to the specific anatomic injury or general surgical procedure performed. Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met. Codes 99291/99292 **and** modifier "-24" (Unrelated evaluation and management service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

30.6.13 – Nursing Facility Visits (Codes 99301 - 99313)

(Rev. 1, 10-01-03)

B3-15509-15509.1

A - Visits to Perform Resident Assessments

Visits necessary to perform all Medicare required assessments are payable. Physicians 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.

B - Visits to Comply With Federal Regulations ([42 CFR 483.40](#))

Payment is made 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 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

Payment is made 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 use CPT codes for subsequent nursing facility care (99311-99313) when reporting evaluation and management services.

D - Visits by Nonphysician Practitioners

Visits to comply with Federal Regulations in SNFs after the initial visit by the physician may, at the option of the physician, be provided by a nonphysician practitioner, i.e., physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS). (Refer to [42 CFR 483.40\(4\) and \(e\)](#) and B3-45-15.)

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 a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (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.

Services provided by physician-employed or independent nonphysician 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 Act) for each resident. Claims for an unreasonable number of visits to residents at a facility within a 24-hour period may indicate aberrancy and result in medical review to determine medical necessity. Medical records must document the specific services to each individual resident.

30.6.14 - Home Care and Domiciliary Care Visits (Codes 99321 - 99350)

(Rev. 168, 05-07-04)

B3-15510

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.

30.6.14.1 - Home Services (Codes 99341 - 99350)

(Rev. 1, 10-01-03)

B3-15515, B3-15066

A - Requirement for Physician Presence

Home services codes 99341-99350 are paid when they are billed to report evaluation and management services provided in a private residence. A home visit cannot be billed by a physician unless the physician was actually present in the beneficiary's home.

B - Homebound Status

Under the home health benefit the beneficiary must be confined to the home for services to be covered. For home services provided by a physician using these codes, the beneficiary does not need to be confined to the home. The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.

C - Fee Schedule Payment for Services to Homebound Patients under General Supervision

Payment may be made in some medically underserved areas where there is a lack of medical personnel and home health services 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. Section 10 provides additional information on the provision of services to homebound Medicare patients.

30.6.15 - Prolonged Services and Standby Services (Codes 99354 - 99360)

(Rev. 1, 10-01-03)

B3-15511-15511.3

30.6.15.1 - Prolonged Services (Codes 99354 - 99359) (ZZZ codes)

(Rev. 1, 10-01-03)

A - Required Companion Codes

Prolonged services codes 99354 through 99355 are payable 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, 99341 - 99345, 99347 - 99350;
- 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; or
- The companion codes for 99357 are 99356 and 1 of the evaluation and management codes required for 99357 to be used.

Prolonged services codes 99354 - 99358 are not paid unless they are accompanied by one of these companion codes.

B - Requirement for Physician Presence

Physicians may 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

Documentation is not required to accompany the bill for prolonged services unless the physician has been selected for medical review. Documentation is required in the medical record about the duration and content of the evaluation and management code

billed and to show that the physician personally furnished the time specified in the HCPCS code definition.

D - Use of the Codes

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. No more than one unit of 99354 is acceptable. 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 1 unit of code 99355. One additional unit of code 99355 is billed for each additional increment of 30 minutes extended duration. Carriers 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.

Threshold Time for Prolonged Visit Codes 99354 and/or 99355 Billed with Office/Outpatient 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

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
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. Carriers 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. Carriers 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.

**Threshold Time for Prolonged Visit Codes 99356 and/or 99357
Billed with Office/Outpatient and Consultation Codes**

Code	Typical 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
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

Carriers must 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

EXAMPLE 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.

EXAMPLE 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

EXAMPLE 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.

EXAMPLE 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.

30.6.15.2 - Prolonged Services Without Face to Face Service (Codes 99358 - 99359)

(Rev. 1, 10-01-03)

Carriers may 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.

30.6.15.3 - Physician Standby Service (Code 99360)

(Rev. 1, 10-01-03)

Standby services are not payable to physicians. Physicians may not bill Medicare or beneficiaries for standby services. Payment for standby services is included in the Part A payment to the facility. Such services are a part of hospital costs to provide quality care. If hospitals pay physicians for standby services, such services are part of hospital costs to provide quality care.

30.6.16 - Case Management Services (Codes 99362 and 99371 - 99373)

(Rev. 1, 10-01-03)

B3-15512

A - Team Conferences

Team conferences (codes 99361-99362) may not be paid separately. Payment for these services is included in the payment for the services to which they relate.

B - Telephone Calls

Telephone calls (codes 99371-99373) may not be paid separately. Payment for telephone calls is included in payment for billable services (e.g., visit, surgery, diagnostic procedure results).

40 - Surgeons and Global Surgery

(Rev. 1, 10-01-03)

B3-4820

A national definition of a global surgical package has been established to ensure that payment is made consistently for the same services across all carrier jurisdictions, thus preventing Medicare payments for services that are more or less comprehensive than intended. The national global surgery policy became effective for surgeries performed on and after January 1, 1992.

The instructions that follow describe the components of a global surgical package and payment rules for minor surgeries, endoscopies and global surgical packages that are split between two or more physicians. In addition, billing, mandatory edits, claims review, adjudication, and postpayment instructions are included.

In addition to the global policy, uniform payment policies and claims processing requirements have been established for other surgical issues, including bilateral and multiple surgeries, co-surgeons, and team surgeries.

40.1 - Definition of a Global Surgical Package

(Rev. 1, 10-01-03)

B3-4821, B3-15900.2

Field 16 of the Medicare Fee Schedule Data Base (MFSDB) provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY.

Codes with “090” in Field 16 are major surgeries. Codes with “000” or “010” are either minor surgical procedures or endoscopies.

Codes with “YYY” are carrier-priced codes, for which carriers determine the global period (the global period for these codes will be 0, 10, or 90 days). Note that not all carrier-priced codes have a “YYY” global surgical indicator; sometimes the global period is specified.

While codes with “ZZZ” are surgical codes, they are add-on codes that are always billed with another service. There is no postoperative work included in the fee schedule payment for the “ZZZ” codes. Payment is made for both the primary and the add-on codes, and the global period assigned is applied to the primary code.

A - Components of a Global Surgical Package

(Rev. 1, 10-01-03)

B3-15011, B3-4820-4831

Carriers apply the national definition of a global surgical package to all procedures with the appropriate entry in Field 16 of the MFSDB.

The Medicare approved amount for these procedures includes payment for the following services related to the surgery when furnished by the physician who performs the surgery. The services included in the global surgical package may be furnished in any setting, e.g., in hospitals, ASCs, physicians’ offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, critical care services (99291 and 99292) are payable separately in some situations.

- Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Intra-operative Services - Intra-operative services that are normally a usual and necessary part of a surgical procedure;

- Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical Pain Management - By the surgeon;
- Supplies - Except for those identified as exclusions; and
- Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

B - Services Not Included in the Global Surgical Package

Carriers do not include the services listed below in the payment amount for a procedure with the appropriate indicator in Field 16 of the MFSDB. These services may be paid for separately.

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Please note that this policy only applies to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure;
- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record;
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy (codes 61533, 61534-61536, 61539, 61541, and 61543) which may be performed in succession within 90 days of each other;

- Treatment for postoperative complications which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR);
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;
- For certain services performed in a physician's office, separate payment can no longer be made for a surgical tray (code A4550). This code is now a Status B and is no longer a separately payable service on or after January 1, 2002. However, splints and casting supplies are payable separately under the reasonable charge payment methodology;
- Immunosuppressive therapy for organ transplants; and
- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

C - Minor Surgeries and Endoscopies

Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.

A postoperative period of 10 days applies to some minor surgeries. The postoperative period for these procedures is indicated in Field 16 of the MFSDB. If the Field 16 entry is 010, carriers do not allow separate payment for postoperative visits or services within 10 days of the surgery that are related to recovery from the procedure. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is payable separately. Services by other physicians are not included in the global fee for a minor procedures except as otherwise excluded. If the Field 16 entry is 000, postoperative visits beyond the day of the procedure are not included in the payment amount for the surgery. Separate payment is made in this instance.

D - Physicians Furnishing Less Than the Full Global Package

B3-4820-4831

There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative, post-discharge care is split between two or more physicians where the physicians agree on the transfer of care.

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global allowed amount).

Where a transfer of care does not occur, the services of another physician may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case.

E - Determining the Duration of a Global Period

To determine the global period for major surgeries, carriers count 1 day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.

EXAMPLE

Date of surgery - January 5

Preoperative period - January 4

Last day of postoperative period - April 5

To determine the global period for minor procedures, carriers count the day of surgery and the appropriate number of days immediately following the date of surgery.

EXAMPLE

Procedure with 10 follow-up days:

Date of surgery - January 5

Last day of postoperative period - January 15

40.2 - Billing Requirements for Global Surgeries

(Rev. 1, 10-01-03)

B3-4822

To ensure the proper identification of services that are, or are not, included in the global package, the following procedures apply.

A - Procedure Codes and Modifiers

Use of the modifiers in this section apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers “-22” and “-25”).

1 - Physicians Who Furnish the Entire Global Surgical Package

Physicians who perform the surgery and furnish all of the usual pre-and postoperative work bill for the global package by entering the appropriate CPT code for the surgical procedure only. Billing is not allowed for visits or other services that are included in the global package.

2 - Physicians in Group Practice

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician. (For dates of service prior to January 1, 1994, however, where a new physician furnishes the entire postoperative care, the group billed for the surgical care and the postoperative care as separate line items with the appropriate modifiers.)

3 - Physicians Who Furnish Part of a Global Surgical Package

Where physicians agree on the transfer of care during the global period, the following modifiers are used:

- “-54” for surgical care only; or
- “-55” for postoperative management only.

Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier.

Providers need not specify on the claim that care has been transferred. However, the date on which care was relinquished or assumed, as applicable, must be shown on the claim. This should be indicated in the remarks field/free text segment on the claim form/format. Both the surgeon and the physician providing the postoperative

care must keep a copy of the written transfer agreement in the beneficiary's medical record.

Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service. Once the physician has seen the patient, that physician may bill for the period beginning with the date on which he/she assumes care of the patient.

Exceptions

- Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate evaluation and management code. No modifiers are necessary on the claim.
- If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care bills using subsequent hospital care codes for the inpatient hospital care and the surgical code with the “-55” modifier for the post-discharge care. The surgeon bills the surgery code with the “-54” modifier.
- Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier.
- If the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate evaluation and management code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular conditions of a patient.

4 - Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery

Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.

In addition to the CPT evaluation and management code, modifier “-57” (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery. (Modifier “-QI” was used for dates of service prior to January 1, 1994.)

If evaluation and management services occur on the day of surgery, the physician bills using modifier “-57,” not “-25.” The “-57” modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine

preoperative service and a visit or consultation is not billed in addition to the procedure.

5 - Return Trips to the Operating Room During the Postoperative Period

When treatment for complications requires a return trip to the operating room, physicians must bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unspecified procedure code in the correct series, i.e., 47999 or 64999. The procedure code for the original surgery is not used except when the **identical** procedure is repeated.

In addition to the CPT code, physicians use CPT modifier “-78” for these return trips (return to the operating room for a related procedure during a postoperative period.)

The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first procedure and requires the use of the operating room, this circumstance may be reported by adding the modifier “-78” to the related procedure.

NOTE: The CPT definition for this modifier does not limit its use to treatment for complications.

6 - Staged or Related Procedures

Modifier “-58” was established to facilitate billing of staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.

The physician may need to indicate that the performance of a procedure or service during the postoperative period was:

- a. Planned prospectively or at the time of the original procedure;
- b. More extensive than the original procedure; or
- c. For therapy following a diagnostic surgical procedure.

These circumstances may be reported by adding modifier “-58” to the staged procedure. A new postoperative period begins when the next procedure in the series is billed.

7 - Unrelated Procedures or Visits During the Postoperative Period

Two CPT modifiers were established to simplify billing for visits and other procedures which are furnished during the postoperative period of a surgical procedure, but which are not included in the payment for the surgical procedure.

Modifier “-79”: Reports an unrelated procedure by the same physician during a postoperative period. The physician may need to indicate that the performance of a procedure or service during a postoperative period was unrelated to the original procedure.

A new postoperative period begins when the unrelated procedure is billed.

Modifier “-24”: Reports an unrelated evaluation and management service by same physician during a postoperative period. The physician may need to indicate that an evaluation and management service was performed during the postoperative period of an unrelated procedure. This circumstance is reported by adding the modifier “-24” to the appropriate level of evaluation and management service.

Services submitted with the “-24” modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. An ICD-9-CM code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

A physician who is responsible for postoperative care and has reported and been paid using modifier “-55” also uses modifier “-24” to report any unrelated visits.

8 - Significant Evaluation and Management on the Day of a Procedure

Modifier “-25” is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made.

It is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier “-25” to the appropriate level of evaluation and management service.

Claims containing evaluation and management codes with modifier “-25” are not subject to prepayment review except in the following situations:

- Effective January 1, 1995, all evaluation and management services provided on the same day as inpatient dialysis are denied without review with the exception of CPT Codes 99221-99223, 99251-99255, and 99238. These codes may be billed with modifier “-25” and reviewed for possible allowance if the evaluation and management service is unrelated to the treatment of ESRD and was not, and could not, have been provided during the dialysis treatment;
- When preoperative critical care codes are being billed for within a global surgical period; and

- When carriers have conducted a specific medical review process and determined, after reviewing the data, that an individual or group have high statistics in terms of the use of modifier “-25,” have done a case-by-case review of the records to verify that the use of modifier “-25” was inappropriate, and have educated the individual or group as to the proper use of this modifier.

9 - Critical Care

Critical care services provided during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances.

Preoperative and postoperative critical care may be paid in addition to a global fee if:

- The patient is critically ill and requires the constant attendance of the physician; and
- The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed.

Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met:

- Codes 99291/99292 and modifier “-25” (for preoperative care) or “-24” (for postoperative care) must be used; and
- Documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

10 - Unusual Circumstances

Surgeries for which services performed are significantly greater than usually required may be billed with the “-22” modifier added to the CPT code for the procedure. Surgeries for which services performed are significantly less than usually required may be billed with the “-52” modifier. The biller must provide:

- A concise statement about how the service differs from the usual; and
- An operative report with the claim.

Modifier “-22” should only be reported with procedure codes that have a global period of 0, 10, or 90 days. There is no such restriction on the use of modifier “-52.”

B - Date(s) of Service

Physicians, who bill for the entire global surgical package or for only a portion of the care, must enter the date on which the surgical procedure was performed in the “From/To” date of service field. This will enable carriers to relate all appropriate billings to the correct surgery. Physicians who share postoperative management with another physician must submit additional information showing when they assumed and relinquished responsibility for the postoperative care. If the physician who performed the surgery relinquishes care at the time of discharge, he or she need only show the date of surgery when billing with modifier “-54.”

However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician. The physician providing the remaining postoperative care must show the date care was assumed. This information should be shown in Item 19 on the paper Form CMS-1500, in the narrative portion of the HA0 record on the National Standard Format, and in the NTE segment for ANSI X12N electronic claims.

C - Care Provided in Different Payment Localities

If portions of the global period are provided in different payment localities, the services should be billed to the carriers servicing each applicable payment locality. For example, if the surgery is performed in one state and the postoperative care is provided in another state, the surgery is billed with modifier “-54” to the carrier servicing the payment locality where the surgery was performed and the postoperative care is billed with modifier “-55” to the carrier servicing the payment locality where the postoperative care was performed. This is true whether the services were performed by the same physician/group or different physicians/groups.

D - Health Professional Shortage Area (HPSA) Payments for Services Which are Subject to the Global Surgery Rules

HPSA bonus payments may be made for global surgeries when the services are provided in HPSAs. The following are guidelines for the appropriate billing procedures:

- If the entire global package is provided in a HPSA, physicians should bill for the appropriate global surgical code with the applicable HPSA modifier.
- If only a portion of the global package is provided in a HPSA, the physician should bill using a HPSA modifier for the portion which is provided in the HPSA.

EXAMPLE

The surgical portion of the global service is provided in a non-HPSA and the postoperative portion is provided in a HPSA. The surgical portion should be billed with the “-54” modifier and no HPSA modifier. The postoperative portion should be billed with the “-55” modifier and the appropriate HPSA modifier. The 10 percent bonus will be paid on the appropriate postoperative portion only. If a claim is submitted with a

global surgical code and a HPSA modifier, the carrier assumes that the entire global service was provided in a HPSA in the absence of evidence otherwise.

NOTE: The sum of the payments made for the surgical and postoperative services provided in different localities will not equal the global amount in either of the localities because of geographic adjustments made through the Geographic Practice Cost Indices.

40.3 - Claims Review for Global Surgeries

(Rev. 1, 10-01-03)

B3-4823

A - Relationship to Correct Coding Initiative (CCI)

The CCI policy and computer edits allow carriers to detect instances of fragmented billing for certain intra-operative services and other services furnished on the same day as the surgery that are considered to be components of the surgical procedure and, therefore, included in the global surgical fee. When both correct coding and global surgery edits apply to the same claim, carriers first apply the correct coding edits, then, apply the global surgery edits to the correctly coded services.

B - Prepayment Edits to Detect Separate Billing of Services Included in the Global Package

In addition to the correct coding edits, carriers must be capable of detecting certain other services included in the payment for a major or minor surgery or for an endoscopy. On a prepayment basis, carriers identify the services that meet the following conditions:

- Preoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure; or
 - Same day or postoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure or endoscopy;
- and -
- Services that were furnished within the prescribed global period of the surgical procedure;
 - Services that are billed without modifier “-78,” “-79,” “-24,” “25,” or “-57” or are billed with modifier “-24” but without the required documentation; and
 - Services that are billed with the same provider or group number as the surgical procedure or endoscopy. Also, edit for any visits billed separately during the postoperative period without modifier “-24” by a physician who billed for the postoperative care only with modifier “-55.”

Carriers use the following evaluation and management codes in establishing edits for visits included in the global package. CPT codes 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99271, 99272, 99273, 99274, and 99275 have been transferred from the excluded category and are now included in the global surgery edits.

Evaluation and Management Codes for Carrier Edits

92012	92014	99211	99212	99213	99214
99215	99217	99218	99219	99220	99221
99222	99223	99231	99232	99233	99234
99235	99236	99238	99239	99241	99242
99243	99244	99245	99251	99252	99253
99254	99255	99261	99262	99263	99271
99272	99273	99274	99275	99291	99292
99301	99302	99303	99311	99312	99313
99315	99316	99331	99332	99333	99347
99348	99349	99350			
99374	99375	99377	99378		

NOTE: In order for codes 99291 or 99292 to be paid for services furnished during the preoperative or postoperative period, modifier “-25” or “-24,” respectively, must be used and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

If a surgeon is admitting a patient to a nursing facility for a condition not related to the global surgical procedure, the physician should bill for the nursing facility admission and care with a “-24” modifier and appropriate documentation. If a surgeon is admitting a patient to a nursing facility and the patient’s admission to that facility relates to the global surgical procedure, the nursing facility admission and any services related to the global surgical procedure are included in the global surgery fee.

C - Exclusions from Prepayment Edits

Carriers exclude the following services from the prepayment audit process and allow separate payment if all usual requirements are met:

- Services listed in §40.1.B; and
- Services billed with the modifier “-25,” “-57,” “-58,” “-78,” or “-79.”

Exceptions

See §§40.2.A.8, 40.2.A.9, and 40.4.A for instances where prepayment review is required for modifier “-25.” In addition, prepayment review is necessary for CPT codes 90935, 90937, 90945, and 90947 when a visit and modifier “-25” are billed with these services.

Exclude the following codes from the prepayment edits required in §40.3.B.

92002	92004	99201	99202	99203	99204
99205	99281	99282	99283	99284	99285
99321	99322	99323	99341	99342	99343
99344	99345				

40.4 - Adjudication of Claims for Global Surgeries

(Rev. 1, 10-01-03)

B3-4824, B3-4825, B3-7100-7120.7

A - Fragmented Billing of Services Included in the Global Package

Since the Medicare fee schedule amount for surgical procedures includes all services that are part of the global surgery package, carriers do not pay more than that amount when a bill is fragmented. When total charges for fragmented services exceed the global fee, process the claim as a fee schedule reduction (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global surgery allowed amount). Carriers do not attribute such reductions to medical review savings except where the usual medical review process results in recoding of a service, and the recoded service is included in the global surgery package.

The maximum a nonparticipating physician may bill a beneficiary on an unassigned claim for services included in the global surgery package is the limiting charge for the surgical procedure.

In addition, the limitation of liability provision (§1879 of the Act) does not apply to these determinations since they are fee schedule reductions, not denials based upon medical necessity or custodial care.

Claims for surgeries billed with a “-22” or “-52” modifier, are priced by individual consideration if the statement and documentation required by §40.2.A.10 are included. If the statement and documentation are not submitted with the claim, pricing for “-22” is at the fee schedule rate for the same surgery submitted without the “-22” modifier. Pricing for “-52” is not done without the required documentation.

Separate payment is allowed for visits and procedures billed with modifier “-78,” “-79,” “-24,” “-25,” “-57,” or “-58.” Modifier “-24” must be accompanied by sufficient documentation that the visit is unrelated to the surgery. Also, when used with the critical care codes, modifiers “-24” and “-25” must be accompanied by documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Carriers do not allow separate payment for evaluation and management services furnished on the same day or during the postoperative period of a surgery if the services are billed without modifier “-24,” “-25,” or “-57.” These services should be denied. Carriers do not allow separate payment for visits during the postoperative period that are billed with the modifier “-24” but without sufficient documentation. These services should also be denied. Modifier “-24” is intended for use with services that are absolutely unrelated to the surgery. It is not to be used for the medical management of a patient by the surgeon following surgery. Recognize modifier “-24” only for care following discharge unless:

- The care is for immunotherapy management furnished by the transplant surgeon;
- The care is for critical care for a burn or trauma patient; or
- The documentation demonstrates that the visit occurred during a subsequent hospitalization and the diagnosis supports the fact that it is unrelated to the original surgery.

Carriers do not allow separate payment for an additional procedure(s) with a global surgery fee period if furnished during the postoperative period of a prior procedure and if billed without modifier “-58,” “-78,” or “-79.” These services should be denied. Codes with the global surgery indicator of “XXX” in the MFSDB can be paid separately without a modifier.

B - Claims From Physicians Who Furnish Less Than the Global Package (Split Global Care)

For surgeries performed January 1, 1992, and later, that are billed with either modifier “-54” or “-55,” carriers pay the appropriate percentage of the fee schedule payment. Fields 17-19 of the MFSDB list the appropriate percentages for pre-, intra-, and postoperative care of the total RVUs for major surgical procedures and for minor surgeries with a postoperative period of 10 days. The intra-operative percentage includes postoperative hospital visits.

Procedures with a “000” entry in Field 16 have an entry of “0.0000” in Fields 17-19. Split global care does not apply to these procedures.

Carriers multiply the fee schedule amount (Field 34 or Field 35 of the MFSDB) by this percentage and round to the nearest cent. Assume that a physician who bills with a “-54” modifier has provided both preoperative, intra-operative and postoperative **hospital** services. Pay this physician the combined preoperative and intra-operative portions of the fee schedule payment amount.

Where more than one physician bills for the postoperative care, carriers apportion the postoperative percentage according to the number of days each physician was responsible for the patient’s care by dividing the postoperative allowed amount by the number of post-op days and that amount is multiplied by the number of days each physician saw the patient.

EXAMPLE

Dr. Jones bills for procedure “42145-54” performed on March 1 and states that he cared for the patient through April 29. Dr. Smith bills for procedure “42145-55” and states that she assumed care of the patient on April 30. The percentage of the total fee amount for the postoperative care for this procedure is determined to be 17 percent and the length of the global period is 90 days. Since Dr. Jones provided postoperative care for the first 60 days, he will receive $66 \frac{2}{3}$ percent of the total fee of 17 percent since $60/90 = .6666$. Dr. Smith’s 30 days of service entitle her to $30/90$ or .3333 of the fee.

$$6666 \times .17 = .11333 \text{ or } 11.3\%; \text{ and}$$

$$3338 \times .17 = .057 \text{ or } 5.7\%.$$

Thus, Dr. Jones will be paid at a rate of 11.3 percent (66.7 percent of 17 percent). Dr. Smith will be paid at a rate of 5.7 percent (33.3 percent of 17 percent).

C - Payment for Return Trips to the Operating Room for Treatment of Complications

When a CPT code billed with modifier “-78” describes the services involving a return trip to the operating room to deal with complications, carriers pay the value of the intra-operative services of the code that describes the treatment of the complications. Refer to Field 18 of the MFSDB to determine the percentage of the global package for the intra-operative services. The fee schedule amount (Field 34 or 35 of the MFSDB) is multiplied by this percentage and rounded to the nearest cent.

When a procedure with a “000” global period is billed with a modifier “-78,” representing a return trip to the operating room to deal with complications, carriers pay the full value for the procedure, since these codes have no pre-, post-, or intra-operative values.

When an unlisted procedure is billed because no code exists to describe the treatment for complications, carriers base payment on a maximum of 50 percent of the value of the intra-operative services originally performed. If multiple surgeries were originally performed, carriers base payment on no more than 50 percent of the value of the intra-operative services of the surgery for which the complications occurred. They multiply the fee schedule amount for the original surgery (Field 34 or 35) by the intra-operative percentage for the procedure (Field 18), and then multiply that figure by 50 percent to obtain the maximum payment amount.

[.50 X (fee schedule amount x intra-operative percentage)]. Round to the nearest cent.

If additional procedures are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery, carriers pay the additional procedures as multiple surgeries. Only surgeries that require a return to the operating room are paid under the complications rules.

If the patient is returned to the operating room after the initial operative session, but on the same day as the original surgery for one or more additional procedures as a result of complications from the original surgery, the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not also apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for bilateral procedures that are required as a result of complications from the original surgery, the complication rules would apply. The bilateral rules would not apply.

D - MSN and Remittance Messages

When carriers deny separate payment for a visit because it is included in the global package, include one of the following statements on the MSN to the beneficiary and the remittance notice sent to the physician. Remittance messages and codes in detail can be found at: <http://www.cms.hhs.gov/medlearn/appmsn.pdf>.

1 - Messages for Fragmented Billing by a Single Physician

When a single physician bills separately for services included in the global surgical package, carriers include one of the following statements on the MSN and remittance advice.

MSN:

23.1 - “The cost of care before and after the surgery or procedure is included in the approved amount for that service. You should not be billed for this item or service. You do not have to pay this amount.” (add on message 16.34)

Remittance Record

“Claim/service denied/reduced because this procedure/service is not paid separately.” (Reason Code B15. Group code CO 97)

2 - Messages for Global Packages Split Between Two or More Physicians

When a physician furnishes only the pre- and intra-operative services, but bills for the entire package, the following statements on the MSN and remittance advice.

23.5 - “Payment has been reduced because a different doctor took care of you before and/or after the surgery. You should not be billed for this item or service. You do not have to pay this amount.” (add on message 16.34)

Remittance Record

“Charges denied/reduced because procedure/service was partially or fully furnished by another physician.” (Reason Code B20, Group Code CO B20)

3 - Message for Procedure Codes With “ZZZ” Global Period Billed as Stand-Alone Procedures

When a physician bills for a surgery with a “ZZZ” global period without billing for another service, include one of the following statements on the MSN and remittance notice.

Carriers include the following message on the MSN for claims:

9.2 - “This item or service was denied because information required to make payment was missing.” (CO 16)

9.3 - “Please ask your provider to submit a new, complete claim to us.”

(NOTE: Add on to other messages as appropriate).

16. When using 16, carriers should also use a claim remark code such as a return/reject code (MA 29MA 43, etc.) to show why claim rejected as incomplete.

4 - Message for Payment Amount When Modifier “-22” Is Submitted Without Documentation

When a physician submits a claim with modifier “-22” but does not provide additional documentation, use the following or a similar remittance advice message:

9.7 - “We have asked your provider to resubmit the claim with the missing or correct information.” (**NOTE:** Add on to other messages as appropriate.) MA 130

40.5 - Postpayment Issues

(Rev. 1, 10-01-03)

B3-4825

It may not always be possible to identify instances where more than one physician furnishes postoperative care before the carrier has paid at least one of the physicians. In addition, situations where a physician renders less than the full global package but does not add the applicable modifier to the procedure code are not detectable until another physician submits a claim.

Several other categories of fragmented bills cannot be or are difficult to detect on a prepayment basis. When a new claim reveals fragmented billing by a single provider after payment for some services was already made to that physician, carriers must adjust the amount due on the new claim by the amount previously paid.

When a new claim indicates that an incorrect payment may have been made to another physician who submitted a previous bill, carriers must determine which bill is correct. (Review the claims and any submitted records to be sure that the providers correctly used modifiers and are billing for services that are included in the global fee. If necessary, a carrier representative must contact one or both physicians to determine which claim is correct.) If the carrier determines that the first claim is incorrect, they follow the overpayment procedures in the Medicare Financial Management Manual, Chapter 3, for recovery of the incorrect payment from the first physician. They pay the second physician according to the services performed. If the carrier determines that the second claim is incorrect, they deny payment and include the following message on the MSN:

English: “This service/item is a duplicate of a previously processed service. No appeal rights are attached to the denial of this service except for the issue as to whether the service is a duplicate. Disregard the appeals information on this notice unless you are appealing whether the service is a duplicate.” (MSN message 7.3)

Spanish: “Este servicio/artículo es un duplicado de otro servicio procesado previamente. No tiene derechos de apelación por la denegación de este servicio, excepto si cuestiona que este servicio es un duplicado. Haga caso omiso a la

información sobre apelaciones en esta notificación, en relación a sus derechos de apelación, a menos que esté apelando si el servicio fue duplicado.”

Carriers must include the following message on the remittance advice:

“Charges denied/reduced because procedure/service was partially/fully furnished by another provider.” (Reason Code B20.)

Carriers must include the appropriate language regarding beneficiary liability according to §40.4.D, above.

Nonparticipating physicians who furnish less than the full global package, but who bill for the entire global surgery, may be guilty of violating their charge limits. In addition, physicians who engage in such practices may be guilty of fraud. See the Medicare Financial Management Manual, Chapter 3, and the Medicare Program Integrity Manual, Chapter 3, for further information on recovery of overpayments, charge limit monitoring, and fraud.

40.6 - Claims for Multiple Surgeries

(Rev. 1, 10-01-03)

B3-4826, B3-15038, B3-15056

A - General

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable. See Chapter 23 for a description of mandatory edits to prevent separate payment for those procedures. Major surgical procedures are determined based on the MFSDB approved amount and not on the submitted amount from the providers. The major surgery, as based on the MFSDB, may or may not be the one with the larger submitted amount.

Also, see subsection D below for a description of the standard payment policy on multiple surgeries. However, these standard payment rules are not appropriate for certain procedures. Field 21 of the MFSDB indicates whether the standard payment policy rules apply to a multiple surgery, or whether special payment rules apply. Site of service payment adjustments (codes with an indicator of “1” in Field 27 of the MFSDB) should be applied before multiple surgery payment adjustments.

B - Billing Instructions

The following procedures apply when billing for multiple surgeries by the same physician on the same day.

- Report the more major surgical procedure without the multiple procedures modifier “-51.”
- Report additional surgical procedures performed by the surgeon on the same day with modifier “-51.”

There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases). When this occurs, the payment adjustment rules for multiple surgeries may not be appropriate. In such cases, the physician does not use modifier “-51” unless one of the surgeons individually performs multiple surgeries.

C - Carrier Claims Processing System Requirements

Carriers must be able to:

1. Identify multiple surgeries by both of the following methods:
 - The presence on the claim form or electronic submission of the “-51” modifier; and
 - The billing of more than one separately payable surgical procedure by the same physician performed on the same patient on the same day, whether on different lines or with a number greater than 1 in the units column on the claim form or inappropriately billed with modifier “-78” (i.e., after the global period has expired);
2. Access Field 34 of the MFSDB to determine the Medicare fee schedule payment amount for each surgery;
3. Access Field 21 for each procedure of the MFSDB to determine if the payment rules for multiple surgeries apply to any of the multiple surgeries billed on the same day;
4. If Field 21 for any of the multiple procedures contains an indicator of “0,” the multiple surgery rules do not apply to that procedure. Base payment on the lower of the billed amount or the fee schedule amount (Field 34 or 35) for each code unless other payment adjustment rules apply;
5. For dates of service prior to January 1, 1995, if Field 21 contains an indicator of “1,” the standard rules for pricing multiple surgeries apply (see items 6-8 below);

6. Rank the surgeries subject to the standard multiple surgery rules (indicator “1”) in descending order by the Medicare fee schedule amount;
7. Base payment for each ranked procedure on the lower of the billed amount, or:
 - 100 percent of the fee schedule amount (Field 34 or 35) for the highest valued procedure;
 - 50 percent of the fee schedule amount for the second highest valued procedure; and
 - 25 percent of the fee schedule amount for the third through the fifth highest valued procedures;
8. If more than five procedures are billed, pay for the first five according to the rules listed in 5, 6, and 7 above and suspend the sixth and subsequent procedures for manual review and payment, if appropriate, “by report.” Payment determined on a “by report” basis for these codes should never be lower than 25 percent of the full payment amount;
9. For dates of service on or after January 1, 1995, new standard rules for pricing multiple surgeries apply. If Field 21 contains an indicator of “2,” these new standard rules apply (see items 10-12 below);
10. Rank the surgeries subject to the multiple surgery rules (indicator “2”) in descending order by the Medicare fee schedule amount;
11. Base payment for each ranked procedure (indicator “2”) on the lower of the billed amount:
 - 100 percent of the fee schedule amount (Field 34 or 35) for the highest valued procedure; and
 - 50 percent of the fee schedule amount for the second through the fifth highest valued procedures; or
12. If more than five procedures with an indicator of “2” are billed, pay for the first five according to the rules listed in 9, 10, and 11 above and suspend the sixth and subsequent procedures for manual review and payment, if appropriate, “by report.” Payment determined on a “by report” basis for these codes should never be lower than 50 percent of the full payment amount. Pay by the unit for services that are already reduced (e.g., 17003). Pay for 17340 only once per session, regardless of how many lesions were destroyed;

NOTE: For dates of service prior to January 1, 1995, the multiple surgery indicator of “2” indicated that special dermatology rules applied. The payment rules for these codes have not changed. The rules were expanded, however, to all codes that previously had a multiple surgery indicator of “1.” For dates of service

prior to January 1, 1995, if a dermatological procedure with an indicator of “2” was billed with the “-51” modifier with other procedures that are **not** dermatological procedures (procedures with an indicator of “1” in Field 21), the standard multiple surgery rules applied. Pay no less than 50 percent for the dermatological procedures with an indicator of “2.” See §§40.6.C.6-8 for required actions.

13. If Field 21 contains an indicator of “3,” and multiple endoscopies are billed, the special rules for multiple endoscopic procedures apply. Pay the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy. Access Field 31A of the MFSDB to determine the base endoscopy.

EXAMPLE

In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).

Carriers assume the following fee schedule amounts for these codes:

45378 - \$255.40

45380 - \$285.98

45385 - \$374.56

Pay the full value of 45385 (\$374.56), plus the difference between 45380 and 45378 (\$30.58), for a total of \$405.14.

NOTE: If an endoscopic procedure with an indicator of “3” is billed with the “-51” modifier with other procedures that are **not** endoscopies (procedures with an indicator of “1” in Field 21), the standard multiple surgery rules apply. See §§40.6.C.6-8 for required actions.

14. Apply the following rules where endoscopies are performed on the same day as unrelated endoscopies or other surgical procedures:

- Two unrelated endoscopies (e.g., 46606 and 43217): Apply the usual multiple surgery rules;
- Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608): Apply the special endoscopy rules to each series and then apply

the multiple surgery rules. Consider the total payment for each set of endoscopies as one service;

- Two related endoscopies and a third, unrelated procedure: Apply the special endoscopic rules to the related endoscopies, and, then apply the multiple surgery rules. Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.

15. If two or more multiple surgeries are of equal value, rank them in descending dollar order billed and base payment on the percentages listed above (i.e., 100 percent for the first billed procedure, 50 percent for the second, etc.);
16. If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions. See §40.7 for bilateral surgery payment instructions.);
17. Round all adjusted payment amounts to the nearest cent;
18. If some of the surgeries are subject to special rules while others are subject to the standard rules, automate pricing to the extent possible. If necessary, price manually;
19. In cases of multiple interventional radiological procedures, both the radiology code and the primary surgical code are paid at 100 percent of the fee schedule amount. The subsequent surgical procedures are paid at the standard multiple surgical percentages (50 percent, 50 percent, 50 percent and 50 percent);
20. Apply the requirements in §§40 on global surgeries to multiple surgeries;
21. Retain the “-51” modifier in history for any multiple surgeries paid at less than the full global amount; and
22. Follow the instructions on adjudicating surgery claims submitted with the “-22” modifier. Review documentation to determine if full payment should be made for those distinctly different, unrelated surgeries performed by different physicians on the same day.

D - Ranking of Same Day Multiple Surgeries When One Surgery Has a “-22” Modifier and Additional Payment is Allowed

(Rev. 1, 10-01-03)

B3-4826

If the patient returns to the operating room after the initial operative session on the same day as a result of complications from the original surgery, the complications rules apply

to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not apply.

However, if the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.

Multiple surgeries are defined as separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable. See Chapter 23 for a description of mandatory edits to prevent separate payment for those procedures.

40.7 - Claims for Bilateral Surgeries

(Rev. 1, 10-01-03)

B3-4827, B3-15040

A - General

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.

The terminology for some procedure codes includes the terms “bilateral” (e.g., code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or “unilateral or bilateral” (e.g., code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as “bilateral” or “unilateral or bilateral” since the fee schedule reflects any additional work required for bilateral surgeries.

Field 22 of the MFSDB indicates whether the payment adjustment rules apply to a surgical procedure.

B - Billing Instructions for Bilateral Surgeries

If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier “-50.” They report such procedures as a single line item. (**NOTE:** This differs from the CPT coding guidelines which indicate that bilateral procedures should be billed as two line items.)

If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, physicians do not report the procedure with modifier “-50.”

C - Claims Processing System Requirements

Carriers must be able to:

1. Identify bilateral surgeries by the presence on the claim form or electronic submission of the “-50” modifier **or** of the same code on separate lines reported once with modifier “-LT” and once with modifier “-RT”;
2. Access Field 34 or 35 of the MFSDB to determine the Medicare payment amount;
3. Access Field 22 of the MFSDB:
 - If Field 22 contains an indicator of “0,” “2,” or “3,” the payment adjustment rules for bilateral surgeries do not apply. Base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply.

NOTE: Some codes which have a bilateral indicator of “0” in the MFSDB may be performed more than once on a given day. These are services that would never be considered bilateral and thus should not be billed with modifier “-50.” Where such a code is billed on multiple line items or with more than 1 in the units field and carriers have determined that the code may be reported more than once, bypass the “0” bilateral indicator and refer to the multiple surgery field for pricing;

- If Field 22 contains an indicator of “1,” the standard adjustment rules apply. Base payment on the lower of the billed amount or 150 percent of the fee schedule amount (Field 34 or 35). (Multiply the payment amount in Field 34 or 35 for the surgery by 150 percent and round to the nearest cent.)
4. Apply the requirements §§40 - 40.4 on global surgeries to bilateral surgeries; and
 5. Retain the “-50” modifier in history for any bilateral surgeries paid at the adjusted amount.

(NOTE: The “-50” modifier is not retained for surgeries which are bilateral by definition such as code 27395.)

40.8 - Claims for Co-Surgeons and Team Surgeons

(Rev. 1, 10-01-03)

B3-4828, B3-15046

A - General

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

B - Billing Instructions

The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons:

- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-62.” Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the MFSDB. (See §40.8.C.5.);
- If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-66.” Field 25 of the MFSDB identifies certain services submitted with a “-66” modifier which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing “by report.”
- If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services. (See §40.6 for multiple surgery payment rules.)

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.

C - Claims Processing System Requirements

Carriers must be able to:

1. Identify a surgical procedure performed by two surgeons or a team of surgeons by the presence on the claim form or electronic submission of the “-62” or “-66” modifier;
2. Access Field 34 or 35 of the MFSDB to determine the fee schedule payment amount for the surgery;
3. Access Field 24 or 25, as appropriate, of the MFSDB. These fields provide guidance on whether two or team surgeons are generally required for the surgical procedure;
4. If the surgery is billed with a “-62” or “-66” modifier and Field 24 or 25 contains an indicator of “0,” payment adjustment rules for two or team surgeons do not apply:
 - Carriers pay the first bill submitted, and base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply;
 - Carriers deny bills received subsequently from other physicians and use the appropriate MSN message in §§40.8.D. As these are medical necessity denials, the instructions in the Program Integrity Manual regarding denial of unassigned claims for medical necessity are applied;
5. If the surgery is billed with a “-62” modifier and Field 24 contains an indicator of “1,” suspend the claim for manual review of any documentation submitted with the claim. If the documentation supports the need for co-surgeons, base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount (Field 34 or 35);
6. If the surgery is billed with a “-62” modifier and Field 24 contains an indicator of “2,” payment rules for two surgeons apply. Carriers base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount (Field 34 or 35);
7. If the surgery is billed with a “-66” modifier and Field 25 contains an indicator of “1,” carriers suspend the claim for manual review. If carriers determine that team surgeons were medically necessary, each physician is paid on a “by report” basis;
8. If the surgery is billed with a “-66” modifier and Field 25 contains an indicator of “2,” carriers pay “by report”;

NOTE: A Medicare fee may have been established for some surgical procedures that are billed with the “-66” modifier. In these cases, all physicians on the team

must agree on the percentage of the Medicare payment amount each is to receive. If carriers receive a bill with a “-66” modifier after carriers have paid one surgeon the full Medicare payment amount (on a bill **without** the modifier), deny the subsequent claim.

9. Apply the rules global surgical packages to each of the physicians participating in a co- or team surgery; and
10. Retain the “-62” and “-66” modifiers in history for any co- or team surgeries.

D - Beneficiary Liability on Denied Claims for Assistant, Co- surgeon and Team Surgeons

MSN message 23.10 which states “Medicare does not pay for a surgical assistant for this kind of surgery,” was established for denial of claims for assistant surgeons. Where such payment is denied because the procedure is subject to the statutory restriction against payment for assistants-at-surgery. Carriers include the following statement in the MSN:

"You cannot be charged for this service." (Unnumbered add-on message.)

Carriers use Group Code CO on the remittance advice to the physician to signify that the beneficiary may not be billed for the denied service and that the physician could be subject to penalties if a bill is issued to the beneficiary.

If Field 23 of the MFSDDB contains an indicator of “0” or “1” (assistant-at-surgery may not be paid) for procedures CMS has determined that an assistant surgeon is not generally medically necessary.

For those procedures with an indicator of “0,” the limitation on liability provisions described in Chapter 30 apply to assigned claims. Therefore, carriers include the appropriate limitation of liability language from Chapter 21. For unassigned claims, apply the rules in the Program Integrity Manual concerning denial for medical necessity.

Where payment may not be made for a co- or team surgeon, use the following MSN message (MSN message number 15.13):

Medicare does not pay for team surgeons for this procedure.

Where payment may not be made for a two surgeons, use the following MSN message (MSN message number 15.12):

Medicare does not pay for two surgeons for this procedure.

Also see limitation of liability remittance notice REF remark codes M25, M26, and M27.

Use the following message on the remittance notice:

Multiple physicians/assistants are not covered in this case. (Reason code 54.)

40.9 - Procedures Billed With Two or More Surgical Modifiers

(Rev. 1, 10-01-03)

B3-4829

Carriers may receive claims for surgical procedures with more than one surgical modifier. For example, since the global fee concept applies to all major surgeries, carriers may receive a claim for surgical care only (modifier “-54”) for a bilateral surgery (modifier “-50”). They may also receive a claim for multiple surgeries requiring the use of an assistant surgeon.

Following is a list of possible combinations of surgical modifiers.

(NOTE: Carriers must price all claims for surgical teams “by report.”)

- Bilateral surgery (“-50”) and multiple surgery (“-51”).
- Bilateral surgery (“-50”) and surgical care only (“-54”).
- Bilateral surgery (“-50”) and postoperative care only (“55”).
- Bilateral surgery (“-50”) and two surgeons (“-62”).
- Bilateral surgery (“-50”) and surgical team (“-66”).
- Bilateral surgery (“-50”) and assistant surgeon (“-80”).
- Bilateral surgery (“-50”), two surgeons (“-62”), and surgical care only (“-54”).
- Bilateral surgery (“-50”), team surgery (“-66”), and surgical care only (“-54”).
- Multiple surgery (“-51”) and surgical care only (“-54”).
- Multiple surgery (“-51”) and postoperative care only (“55”).
- Multiple surgery (“-51”) and two surgeons (“-62”).
- Multiple surgery (“-51”) and surgical team (“-66”).
- Multiple surgery (“-51”) and assistant surgeon (“-80”).
- Multiple surgery (“-51”), two surgeons (“-62”), and surgical care only (“-54”).
- Multiple surgery (“-51”), team surgery (“-66”), and surgical care only (“-54”).
- Two surgeons (“-62”) and surgical care only (“-54”).
- Two surgeons (“-62”) and postoperative care only (“55”).

- Surgical team (“-66”) and surgical care only (“-54”).
- Surgical team (“-66”) and postoperative care only (“55”).

Payment is not generally allowed for an assistant surgeon when payment for either two surgeons (modifier “-62”) or team surgeons (modifier “-66”) is appropriate. If carriers receive a bill for an assistant surgeon following payment for co-surgeons or team surgeons, they pay for the assistant only if a review of the claim verifies medical necessity.

50 - Payment for Anesthesiology Services

(Rev. 1, 10-01-03)

B3-15018

A - General Payment Rule

The fee schedule amount for physician anesthesia services furnished on or after January 1, 1992 is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is listed in §50.K, Exhibit 1. The way in which time units are calculated is described in §50.G. CMS releases the conversion factor annually. Carriers may not allow separate payment for the anesthesia service performed by the physician who also furnishes the medical or surgical service. In that case, payment for the anesthesia service is made through the payment for the medical or surgical service. For example, carriers may not allow separate payment for the surgeon’s performance of a local or surgical anesthesia if the surgeon also performs the surgical procedure. Similarly, separate payment is not allowed for the psychiatrist’s performance of the anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs the electroconvulsive therapy.

B - Payment at Personally Performed Rate

Carriers must determine the fee schedule payment, recognizing the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

- The physician personally performed the entire anesthesia service alone;
- The physician is involved with one anesthesia case with a resident, the physician is a teaching physician as defined in §100, and the service is furnished on or after January 1, 1996;
- The physician is continuously involved in a single case involving a student nurse anesthetist;
- The physician is continuously involved in one anesthesia case involving a CRNA (or AA) and the service was furnished prior to January 1, 1998. If the physician is

involved with a single case with a CRNA (or AA) and the service was furnished on or after January 1, 1998, carriers may pay the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy; or

- The physician and the CRNA (or AA) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the “AA” modifier and the CRNA reports the “QZ” modifier for a nonmedically directed case.

C - Payment at the Medically Directed Rate

Carriers determine payment for the physician’s medical direction service furnished on or after January 1, 1998 on the basis of 50 percent of the allowance for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities.

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides indicated-post-anesthesia care.

Prior to January 1, 1999 the physician was required to participate in the most demanding procedures of the anesthesia plan, including induction and emergence.

For medical direction services furnished on or after January 1, 1999, the physician must participate only in the most demanding procedures of the anesthesia plan, including, if applicable, induction and emergence. Also for medical direction services furnished on or after January 1, 1999, the physician must document in the medical record that he or she performed the pre-anesthetic examination and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

For services furnished on or after January 1, 1994, the physician can medically direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of these individuals. The medical direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern or resident.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who furnished them.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature. Carriers may not make payment under the fee schedule.

See §50.J for a definition of concurrent anesthesia procedures.

D - Payment at Medically Supervised Rate

Carriers may allow only three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document he or she was present at induction.

E - Billing and Payment for Multiple Anesthesia Procedures

B3-4830.C and D

Physicians bill for the anesthesia services associated with multiple bilateral surgeries by reporting the anesthesia procedure with the highest base unit value with the multiple

procedure modifier “-51.” They report the total time for all procedures in the line item with the highest base unit value.

If the same anesthesia CPT code applies to two or more of the surgical procedures, billers enter the anesthesia code with the “-51” modifier and the number of surgeries to which the modified CPT code applies.

Payment can be made under the fee schedule for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures. Payment is determined based on the base unit of the anesthesia procedure with the highest base unit value and time units based on the actual anesthesia time of the multiple procedures. See §§40.6-40.7 for a definition and appropriate billing and claims processing instructions for multiple and bilateral surgeries.

F - Payment for Medical and Surgical Services Furnished in Addition to Anesthesia Procedure

Payment may be made under the fee schedule for specific medical and surgical services furnished by the anesthesiologist as long as these services are reasonable and medically necessary or provided that other rebundling provisions (see §30 and Chapter 23) do not preclude separate payment. These services may be furnished in conjunction with the anesthesia procedure to the patient or may be furnished as single services, e.g., during the day of or the day before the anesthesia service. These services include the insertion of a Swan Ganz catheter, the insertion of central venous pressure lines, emergency intubation, and critical care visits.

G - Anesthesia Time and Calculation of Anesthesia Time Units

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished on or after January 1, 2000, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished on or after January 1, 1994, carriers compute time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place. Carriers do not recognize time units for CPT codes 01995 or 01996.

For purposes of this section, anesthesia practitioner means a physician who performs the anesthesia service alone, a CRNA who is not medically directed, or a CRNA or AA, who is medically directed. The physician who medically directs the CRNA or AA would ordinarily report the same time as the CRNA or AA reports for the CRNA service.

H - Base Unit Reduction for Concurrent Medically Directed Procedures

If the physician medically directs concurrent medically directed procedures prior to January 1, 1994, reduce the number of base units for each concurrent procedure as follows.

- For two concurrent procedures, the base unit on each procedure is reduced 10 percent.
- For three concurrent procedures, the base unit on each procedure is reduced 25 percent.
- For four concurrent procedures, the base on each concurrent procedure is reduced 40 percent.
- If the physician medically directs concurrent procedures prior to January 1, 1994, and any of the concurrent procedures are cataract or iridectomy anesthesia, reduce the base units for each cataract or iridectomy procedure by 10 percent.

I - Monitored Anesthesia Care

Carriers pay for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services. Anesthesiologists use modifier QS to report monitored anesthesia care cases. Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated postoperative anesthesia care.

Payment is made under the fee schedule using the payment rules in subsection B if the physician personally performs the monitored anesthesia care case or under the rules in subsection C if the physician medically directs four or fewer concurrent cases and monitored anesthesia care represents one or more of these concurrent cases.

J - Definition of Concurrent Medically Directed Anesthesia Procedures

Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicare patient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-Medicare patients and the remaining a Medicare patient, this represents three concurrent cases. The following example illustrates this concept and guides physicians in determining how many procedures they are directing.

EXAMPLE

Procedures A through E are medically directed procedures involving CRNAs and furnished between January 1, 1992 and December 31, 1997 (1998 concurrent instructions can be found in subsection C.) The starting and ending times for each procedure represent the periods during which anesthesia time is counted. Assume that none of the procedures were cataract or iridectomy anesthesia.

Procedure A begins at 8:00 a.m. and lasts until 8:20 a.m.

Procedure B begins at 8:10 a.m. and lasts until 8:45 a.m.

Procedure C begins at 8:30 a.m. and lasts until 9:15 a.m.

Procedure D begins at 9:00 a.m. and lasts until 12:00 noon.

Procedure E begins at 9:10 a.m. and lasts until 9:55 a.m.

Procedure	Number of Concurrent Medically Directed Procedures	Base Unit Reduction Percentage
A	2	10%
B	2	10%
C	3	25%
D	3	25%
E	3	25%

From 8:00 a.m. to 8:20 a.m., the length of procedure A, the anesthesiologist medically directed two concurrent procedures, A and B.

From 8:10 a.m. to 8:45 a.m., the length of procedure B, the anesthesiologist medically directed two concurrent procedures. From 8:10 to 8:20 a.m., the anesthesiologist medically directed procedures A and B. From 8:20 to 8:30 a.m., the anesthesiologist medically directed only procedure B. From 8:30 to 8:45 a.m., the anesthesiologist medically directed procedures B and C. Thus, during procedure B, the anesthesiologist medically directed, at most, two concurrent procedures.

From 8:30 a.m. to 9:15 a.m., the length of procedure C, the anesthesiologist medically directed three concurrent procedures. From 8:30 to 8:45 a.m., the anesthesiologist medically directed procedures B and C. From 8:45 to 9:00 a.m., the anesthesiologist medically directed procedure C. From 9:00 to 9:10 a.m., the anesthesiologist medically

directed procedures C and D. From 9:10 to 9:15 a.m., the anesthesiologist medically directed procedures C, D and E. Thus, during procedure C, the anesthesiologist medically directed, at most, three concurrent procedures.

The same analysis shows that during procedure D or E, the anesthesiologist medically directed, at most, three concurrent procedures.

K - Anesthesia Claims Modifiers

B3-4830, B3-15018.K

Physicians report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist

AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures;

G8 - Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedures;

G9 - Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals

QS - Monitored anesthesia care service

QX - CRNA service; with medical direction by a physician

QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist

QZ - CRNA service: Without medical direction by a physician.

The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

Carriers must determine payment for anesthesia in accordance with these instructions. They must be able to determine the uniform base unit that is assigned to the anesthesia code and apply the appropriate reduction where the anesthesia procedures is medically directed. They must also be able to determine the number of anesthesia time units from actual anesthesia time reported on the claim, differentiating 15 minute time unit intervals for personally performed anesthesia procedures and 30 minute time unit intervals for

medically directed procedures. Carriers must multiply allowable units by the anesthesia-specific conversion factor used to determine fee schedule payment for the payment area.

Exhibit 1: Base Unit for Each Anesthesia Procedure

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
00100	Anesthesia for procedures on Integumentary system of head and/or salivary glands, including biopsy; not otherwise specified	5
00102	Plastic repair of cleft lip	6
00103	Anesthesia for procedures in eye, blepharoplasty	5
00104	Anesthesia for electroconvulsive therapy	4
00120	Anesthesia for procedures on external, middle, and inner ear, including biopsy; not otherwise specified	5
00124	Otoscopy	4
00126	Tympanotomy	4
00140	Anesthesia for procedures on eye; not otherwise specified	5
00142	Lens surgery	4
00144	Corneal transplant	6
00145	Vitrectomy	6
00147	Iridectomy	4
00148	Ophthalmoscopy	4
00160	Anesthesia for procedures on nose and accessory sinuses; not otherwise specified	5
00162	Radical surgery	7
00164	Biopsy, soft tissue	4
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified	5

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
00172	Repair of cleft palate	6
00174	Excision of retropharyngeal tumor	6
00176	Radical surgery	7
00190	Anesthesia for procedures on facial bones; not otherwise specified	5
00192	Radical surgery (including prognathism)	7
00210	Anesthesia for intracranial procedures; not otherwise specified	11
00212	Subdural taps	5
00214	Burr holes (For burr holes for ventriculography, see 01902.)	9
00215	Anesthesia for intracranial procedures; elevation of depressed skull fracture, extradural (simple or compound)	9
00216	Vascular procedures	15
00218	Procedures in sitting position	13
00220	Spinal fluid shunting procedures	10
00222	Electrocoagulation of intracranial nerve	6
NECK		
00300	Anesthesia for all procedures on integumentary system of neck, including subcutaneous tissue	5
00320	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified	6
00322	Needle biopsy of thyroid (For procedures on cervical spine and cord see 00600, 00604, 00670)	3
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
00352	Simple ligation (For arteriography; see radiologic procedure 01916)	5
THORAX (CHEST WALL AND SHOULDER GIRDLE)		
00400	Anesthesia for procedures on anterior integumentary system of chest, including subcutaneous tissue; not otherwise specified	3
00402	Reconstructive procedures on breast (e.g.,reduction or augmentation mammoplasty, muscle flaps)	5
00404	Radical or modified radical procedures on breast	5
00406	Radical or modified radical procedures on breast with internal mammary node dissection	
00410	Electrical conversion of arrhythmias	4
00420	Anesthesia for procedures on posterior integumentary system of chest, including subcutaneous tissue	5
00450	Anesthesia for procedures on clavicle and scapula; not otherwise specified	5
00452	Radical surgery	6
00454	Biopsy of clavicle	3
00470	Anesthesia for partial rib resection; not otherwise specified	6
00472	Thoracoplasty (any type)	10
00474	Radical procedures, (e.g., pectus excavatum)	13
INTRATHORACIC		
00500	Anesthesia for all procedures on esophagus	15
00520	Anesthesia for closed chest procedures (including esophagoscopy, bronchoscopy, thoracoscopy); not otherwise specified	6

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
00522	Needle biopsy of pleura	4
00524	Pneumocentesis	4
00528	Mediastinoscopy	8
00530	Anesthesia for transvenous pacemaker insertion	4
00532	Anesthesia for vascular access to central venous circulation	4
00534	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum; not otherwise specified	7
00537	Anesthesia for cardiac electrophys	7
00540	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum; not otherwise specified	13
00542	Decortication	15
00544	Pleurectomy	15
00546	Pulmonary resection with thoracoplasty	15
00548	Intrathoracic repair of trauma to trachea and bronchi	15
00550	Anesthesia for sternal debridement	
00560	Anesthesia for procedures on heart, pericardium, and great vessels of chest; without pump oxygenator	15
00562	With pump oxygenator	20
00563	Anesthesia for heart proc with pump	25
00566	Anesthesia for cabg without pump	25
00580	Anesthesia for heart or heart/lung transplant	20
SPINE AND SPINAL CORD		
00600	Anesthesia for procedures on cervical spine and cord; not otherwise specified (For myelography and discography, see	10

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
radiological procedures 01906-01914.)		
00604	Posterior cervical laminectomy in sitting position	
00620	Anesthesia for procedures on thoracic spine and cord; not otherwise specified	10
00622	Thoracolumbar sympathectomy	13
00630	Anesthesia for procedures in lumbar region; not otherwise specified	8
00632	Lumbar sympathectomy	7
00634	Chemoneucleolysis	10
00635	Anesthesia for lumbar puncture	4
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., Harrington rod technique)	13
UPPER ABDOMEN		
00700	Anesthesia for procedures on upper anterior abdominal wall; not otherwise specified	3
00702	Percutaneous liver biopsy	4
00730	Anesthesia for procedures on upper posterior abdominal wall	5
00740	Anesthesia for upper gastrointestinal endoscopic procedures	5
00750	Anesthesia for hernia repairs in upper abdomen; not otherwise specified	4
00752	Lumbar and ventral (incisional) hernias and/or wound dehiscence	6
00754	Omphalocele	7
00756	Transabdominal repair of diaphragmatic hernia	7
00770	Anesthesia for all procedures on major abdominal blood vessels	15

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7
00792	Partial hepatectomy (excluding liver biopsy)	13
00794	Pancreatectomy, partial or total (e.g., Whipple procedure)	8
00796	Liver transplant (recipient)	30
00797	Anesthesia, surgery for obesity	8
LOWER ABDOMEN		
00800	Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified	3
00802	Panniculectomy	5
00810	Anesthesia for intestinal endoscopic procedures	6
00820	Anesthesia for procedures on lower posterior abdominal wall	5
00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified	4
00832	Ventral and incisional hernias	
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified	6
00842	Amniocentesis	4
00844	Abdominoperineal resection	7
00846	Radical hysterectomy	8
00848	Pelvic exenteration	8
00851	Anestheisa, tubal ligation	6
00860	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified	6

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
00862	Renal procedures, including upper 1/3 of ureter or donor nephrectomy	7
00864	Total cystectomy	8
00865	Anesthesia for removal of prostate	7
00866	Adrenalectomy	
00868	Renal transplant (recipient) (For donor nephrectomy, use 00862.) (For harvesting kidney from brain-dead patient, use 01990.)	10
00869	Anesthesia for vasectomy	3
00870	Cystolithotomy	5
00872	Anesthesia for lithotripsy, extracorporeal shock wave; with water bath	7
00873	Without water bath	5
00880	Anesthesia for procedures on major lower abdominal vessels; not otherwise specified	15
00882	Inferior vena cava ligation	10
00884	Transvenous umbrella insertion	5
PERINEUM		
00902	Anorectal procedure (including endoscopy and/or biopsy)	4
00904	Radical perineal procedure	7
00906	Vulvectomy	4
00908	Perineal prostatectomy	6
00910	Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified	3

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
00912	Transurethral resection of bladder tumor(s)	5
00914	Transurethral resection of prostate	5
00916	Post-transurethral resection bleeding	5
00918	With fragmentation and/or fragmentation removal of ureteral calculus	5
00920	Anesthesia for procedures on male external genitalia; not otherwise specified	3
00922	Seminal vesicles	6
00924	Undescended testis, unilateral or bilateral	4
00926	Radical orchiectomy, inguinal	4
00928	Radical orchiectomy, abdominal	6
00930	Orchiopexy, unilateral and bilateral	4
00932	Complete amputation of penis	4
00934	Radical amputation of penis with bilateral inguinal lymphadenectomy	6
00936	Radical amputation of penis with bilateral inguinal and iliac lymphadenectomy	8
00938	Insertion of penile prosthesis (perineal approach)	4
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified	3
00942	Colpotomy, colpectomy, colporrhaphy	4
00944	Vaginal hysterectomy	6
00948	Cervical cerlage	4
00950	Culdoscopy	5

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
00952	Hysteroscopy	4
00955	Continuous epidural and analgesic for labor and vaginal delivery	5
PELVIS (EXCEPT HIP)		
01000	Anesthesia for procedures on anterior integumentary system of pelvis (anterior to iliac crest), except external genitalia	3
01110	Anesthesia for procedures on posterior integumentary system of pelvis (posterior to iliac crest), except perineum	5
01112	Anesthesia for bone aspirate/bx	5
01120	Anesthesia for procedures on bony pelvis	6
01130	Anesthesia for body cast application or revision	3
01140	Anesthesia for interpelviabdominal (hind quarter) amputation	15
01150	Anesthesia for radical procedures for tumor of pelvis, except hind quarter amputation	8
01160	Anesthesia for closed procedures involving symphysis pubis or sacroiliac joint	4
01170	Anesthesia for open procedures involving symphysis pubis or sacroiliac joint	8
01180	Anesthesia for obturator neurectomy; extrapelvic	3
01190	Intrapelvic	4
UPPER LEG (EXCEPT KNEE)		
01200	Anesthesia for all closed procedures involving hip joint	4
01202	Anesthesia for arthroscopic procedures of hip joint	4
01210	Anesthesia for open procedures involving hip joint; not otherwise specified	6

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
01212	Hip disarticulation	10
01214	Total hip replacement or revision	10
01215	Anesthesia for revise hip repair	10
01220	Anesthesia for all closed procedures involving upper 2/3 of femur	4
01230	Anesthesia for open procedures involving upper 2/3 of femur; not otherwise specified	6
01232	Amputation	5
01234	Radical resection	8
01240	Anesthesia for all procedures on integumentary system of upper leg	3
01250	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of upper leg	4
01260	Anesthesia for all procedures involving veins of upper leg, including exploration	3
01270	Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified	8
01272	Femoral artery ligation	4
01274	Femoral artery embolectomy	6
KNEE AND POPLITEAL AREA		
01320	Anesthesia for all procedures on nerves, muscles, tendons, fascia and bursae of knee and/or popliteal area	4
01340	Anesthesia for all closed procedures on lower 1/3 of femur	4
01360	Anesthesia for all open procedures on lower 1/3 of femur	5
01380	Anesthesia for all closed procedures on knee joint	3

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
01382	Anesthesia for arthroscopic procedures of knee joint	3
01390	Anesthesia for all closed procedures on upper ends of tibia and fibula, and/or patella	3
01392	Anesthesia for all open procedures on upper ends of tibia and fibula and/or patella	4
01400	Anesthesia for open procedures on knee joint; not otherwise specified	4
01402	Total knee replacement	7
01404	Disarticulation at knee	5
01420	Anesthesia for all cast applications, removal, or repair involving knee joint	3
01430	Anesthesia for procedures on veins of knee and popliteal area; not otherwise specified	3
01432	Arteriovenous fistula	5
01440	Anesthesia for procedures on arteries of knee and Popliteal area; not otherwise specified	5
01442	Popliteal thromboendarterectomy, with or without patch graft	8
01444	Popliteal excision and graft or repair for occlusion or aneurysm	8
LOWER LEG (Below knee - includes ankle and foot)		
01462	Anesthesia for all closed procedures on lower leg, ankle, and foot	3
01464	Anesthesia for arthroscopic procedures of ankle joint	3
01470	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; not otherwise specified	3
01472	Repair of ruptured Achilles tendon, with or without graft	5

CPT Anesthesia Code	Anesthesia Procedure	Base Units
HEAD		
01474	Gastrocnemius recession (e.g., Strayer procedure)	5
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified	3
01482	Radical resection	4
01484	Osteotomy or osteoplasty of tibia and/or fibula	4
01486	Total ankle replacement	7
01490	Anesthesia for lower leg cast application, removal, or repair	3
01500	Anesthesia for procedures on arteries of lower leg, including bypass graft; not otherwise specified	8
01502	Embolectomy, direct or catheter	6
01520	Anesthesia for procedures on veins of lower leg; not otherwise specified	3
01522	Venous thrombectomy, direct or catheter	5

CPT Anesthesia Code	Anesthesia Procedure	Base Units
SHOULDER AND AXILLA (Includes humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint)		
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla	5
	(Includes humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint)	
01620	Anesthesia for all closed procedures on humeral head and neck, sternoclavicular joint, and shoulder joint	4
01622	Anesthesia for arthroscopic procedures of shoulder joint	4
01630	Anesthesia for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5
01632	Radical resection	6
01634	Shoulder disarticulation	9
01636	Interthoracoscapular (forequarter) amputation	15
01638	Total shoulder replacement	10
01650	Anesthesia for procedures on arteries of shoulder and axilla; not otherwise specified	6
01652	Axillary-brachial aneurysm	10
01654	Bypass graft	8
01656	Axillary-femoral bypass graft	10
01670	Anesthesia for all procedures on veins of shoulder and axilla	4
01680	Anesthesia for shoulder cast application, removal or repair; not otherwise specified	3
01682	Shoulder spica	4

CPT Anesthesia Code	Anesthesia Procedure	Base Units
UPPER ARM AND ELBOW		
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, bursae of upper arm and elbow; not otherwise specified	3
01712	Tenotomy, elbow to shoulder, open	5
01714	Tenoplasty, elbow to shoulder	5
01716	Tenodesis, rupture of long tendon of biceps	5
01730	Anesthesia for all closed procedures on humerus and elbow	3
01732	Anesthesia for arthroscopic procedures of elbow joint	3
01740	Anesthesia for open procedures on humerus and elbow; not otherwise specified	4
01742	Osteotomy of humerus	5
01744	Repair of nonunion or malunion of humerus	5
01756	Radical procedures	6
01758	Excision of cyst or tumor of humerus	5
01760	Total elbow replacement	7
01770	Anesthesia for procedures on arteries of upper arm; not otherwise specified	8
01772	Embolectomy	6
01780	Anesthesia for procedures on veins of upper arm and elbow; not otherwise specified	3
01782	Phleborrhaphy	4
FOREARM, WRIST AND HAND		
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, bursae of forearm, wrist, and hand	3

CPT Anesthesia Code	Anesthesia Procedure	Base Units
01820	Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones	3
01830	Anesthesia for open procedures on radius, ulna, wrist, or hand bones; not otherwise specified	3
01832	Total wrist replacement	6
01840	Anesthesia for procedures on arteries of forearm, wrist, and hand; not otherwise specified	6
01842	Embolectomy	6
01844	Anesthesia for vascular shunt, or shunt revision, any type (e.g., dialysis)	6
01850	Anesthesia for procedures on veins of forearm, wrist, and hand; not otherwise specified	3
01852	Phleborrhaphy	4
01860	Anesthesia for forearm, wrist, or hand cast application, removal or repair	3
RADIOLOGICAL PROCEDURES		
01905		5
01916	Anesthesia for arteriograms, needle; carotid, or vertebral	5
01920	Anesthesia for cardiac catheterization including coronary arteriography and ventriculography (not to include Swan-Ganz catheter)	7
01922	Anesthesia for noninvasive imaging or radiation therapy	7
01924	Anesthesia, ther intervene rad, art	5
01925	Anesthesia, ther intervene rad, car	7
01926	Anesthesia, tx interv rad hrt/cran	8
MISCELLANEOUS PROCEDURE(S)		

CPT Anesthesia Code	Anesthesia Procedure	Base Units
01930	Anesthesia, ther intervene rad, vein	5
01931	Anesthesia, ther intervene rad, tip	7
01932	Anesthesia, tx interv rad, th vein	6
01952	Anesthesia, burn, less 4 percent	5
01953	Anesthesia, burn 4-9 percent	5
01960	Anesthesia, vaginal delivery	5
01961	Anesthesia, caesarean delivery	7
01962	Anesthesia, emergency hysterectomy	8
01963	Anesthesia, caesarean hysterectomy	8
01964	Anesthesia, abortion procedures	4
01967	Anesthesia/analg, vaginal delivery	5
01968	Anesthesia/analg caesarean delivery add-on	2
01969	Anesthesia/analg caesarean hysterectomy add-on	5
01990	Physiological support for harvesting of organ(s) from brain-dead patient	7
01995	Region IV administration of local anesthetic agent (upper or lower extremity)	5
01996	Daily management of epidural or subarachnoid drug administration	3
01999	Unlisted anesthesia procedure(s)	I.C.*
*Individual Consideration		

60 - Payment for Pathology Services

(Rev. 1, 10-01-03)

B3-15020, AB-01-47 (CR1499)

A - General Payment Rule

Payment for services to hospital inpatients or outpatients can be made under the fee schedule for the professional component of physician laboratory or pathology services furnished by hospital physicians, usually pathologists. Or the professional component for services may be paid to independent laboratories for covered hospital inpatients and outpatients, and/or for fee for services beneficiaries receiving laboratory services under a pre-existing service agreement. Usually, the technical component is considered a hospital service and should be billed by the hospital to the FI. Payment for the technical component is included in a PPS rate and is payable to a hospital.

See Chapter 16 for additional instruction on laboratory services including clinical diagnostic laboratory services.

Physician laboratory and pathology services are limited to:

- Surgical pathology services;
- Specific cytopathology, hematology and blood banking services that have been identified to require performance by a physician and are listed below;
- Clinical consultation services that meet the requirements in subsection D below; and
- Clinical laboratory interpretation services that meet the requirements and which are specifically listed in subsection E below.

B - Surgical Pathology Services

Surgical pathology services include the gross and microscopic examination of organ tissue performed by a physician, except for autopsies, which are not covered by Medicare. Surgical pathology services paid under the physician fee schedule are reported under the following CPT codes:

88141, 88291, 88300, 88302, 88304, 88305, 88307, 88309, 88311, 88312, 88313, 88314, 88318, 88319, 88321, 88323, 88325, 88329, 88331, 88332, 88342, 88346, 88347, 88348, 88349, 88355, 88356, 88358, 88362, 88365, 89100, 89105, 89130, 89132, 89135, 89136, 89140, and 89141.

Depending upon circumstances and the billing entity, carries may pay professional component, technical component or both.

- While carriers could, prior to January 1, 2001, accept billings under the physician fee schedule from independent laboratories for the technical component of a physician pathology services delivered within as hospital inpatient setting, this is no longer the case.
- Likewise, claims for cytopathology and surgical pathology, physician services provided under the outpatient prospective payment system are no longer covered if submitted by an independent laboratory.
- However, §542 of the Benefits Improvement and Protection Act of 2000 (BIPA) does allow the Medicare carrier to pay for the technical component of physician pathology services when an independent laboratory furnishes these services to a Medicare covered hospital on an inpatient and/or outpatient service.
- In order to meet the definition of a “covered hospital” for the purposes of independent laboratory billing for the technical component, the hospital shall have had a contractual arrangement with an independent laboratory that was effective as of July 22, 1999.
- Through this relationship, independent laboratory billing is only covered for the technical components of physician pathology services delivered to fee-for-service Medicare enrollees who were hospital inpatients and/or outpatients.
- A “fee-for-service” Medicare beneficiary references an enrollee who is not a member of a Medicare managed care plan.
- More specifically, the enrollee must be entitled to Medicare benefits under Part A of the Medicare program, and/or the enrollee must be covered under Part B of Title XVIII.
- As mentioned, the Medicare beneficiary of the pathology services cannot be enrolled in a Medicare + Choice Plan under Part C, a plan offered by an eligible organization under §1894 of the Act, nor a health maintenance demonstration project under Paragraph 4108 of the Omnibus Budget Reconciliation Act of 1987.

Additional exceptions to the noncoverage status of independent laboratories for billing purposes also exists. These exceptions include:

- An independent laboratory that has acquired another independent laboratory that qualifies for continued billing can, by virtue of that acquisition, bill the carrier under the physician fee schedule for the TC of a physician’s pathology services provided to a covered hospital’s inpatient and/or outpatient Medicare fee-for-service clients.

However, documentation must be submitted to the carrier that a pre-July 22, 1999 agreement did exist between the hospital and the laboratory, or the hospital and the predecessor laboratory.

C - Specific Hematology, Cytopathology and Blood Banking Services

Cytopathology services include the examination of cells from fluids, washings, brushings or smears, but generally excluding hematology. Examining cervical and vaginal smears are the most common service in cytopathology. Cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of an abnormality. This microscopic evaluation ordinarily does require performance by a physician. When medically necessary and when furnished by a physician, it is paid under the fee schedule.

These codes include 88104, 88106, 88107, 88108, 88125, 88160, 88161, 88162, 88170, 88171, 88172, 88173, 88180, and 88182.

For services furnished prior to January 1, 1999, carriers pay separately under the physician fee schedule for the interpretation of an abnormal pap smear furnished to a hospital inpatient by a physician. They must pay under the clinical laboratory fee schedule for pap smears furnished in all other situations. This policy also applies to screening pap smears requiring a physician interpretation. For services furnished on or after January 1, 1999, carriers allow separate payment for a physician's interpretation of a pap smear to any patient (i.e., hospital or nonhospital) as long as (1) the laboratory's screening personnel suspect an abnormality; and (2) the physician reviews and interprets the pap smear.

This policy also applies to screening pap smears requiring a physician interpretation and described in the National Coverage Determination Manual and Chapter 18. These services are reported under codes P3000 or P3001.

Physician hematology services include microscopic evaluation of bone marrow aspirations and biopsies. It also includes those limited number of peripheral blood smears which need to be referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist.

These codes include 85060, 38220, 85097, and 38221.

Carriers pay the professional component for the interpretation of an abnormal blood smear (code 85060) furnished to a hospital inpatient by a hospital physician or an independent laboratory.

For the other listed hematology codes, payment may be made for the professional component if the service is furnished to a patient by a hospital physician or independent laboratory. In addition, payment may be made for these services furnished to patients by an independent laboratory.

Codes 38220 and 85097 represent professional-only component services and have no technical component values.

Blood banking services of hematologists and pathologists are paid under the physician fee schedule when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected.

The blood banking codes are 86077, 86078, and 86079 and represent professional component- only services. These codes do not have a technical component.

D - Clinical Consultation Services

Clinical consultations are paid under the physician fee schedule only if they:

1. Are requested by the patient's attending physician;
2. Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient;
3. Result in a written narrative report included in the patient's medical record; and
4. Require the exercise of medical judgment by the consultant physician.

Clinical consultations are a professional component service only. There is no technical component. The clinical consultation codes are 80500 and 80502.

Routine conversations held between a laboratory director and an attending physician about test orders or results do not qualify as consultations unless all four requirements are met. Laboratory personnel, including the director, may from time to time contact attending physicians to report test results or to suggest additional testing or be contacted by attending physicians on similar matters. These contacts do not constitute clinical consultations. However, if in the course of such a contact, the attending physician requests a consultation from the pathologist, and if that consultation meets the other criteria and is properly documented, it is paid under the fee schedule.

EXAMPLE

A pathologist telephones a surgeon about a patient's suitability for surgery based on the results of clinical laboratory test results. During the course of their conversation, the surgeon asks the pathologist whether, based on test results, patient history and medical records, the patient is a candidate for surgery. The surgeon's request requires the pathologist to render a medical judgment and provide a consultation. The pathologist follows up his/her oral advice with a written report and the surgeon notes in the patient's medical record that he/she requested a consultation. This consultation is paid under the fee schedule.

In any case, if the information could ordinarily be furnished by a nonphysician laboratory specialist, the service of the physician is not a consultation payable under the fee schedule.

See the Program Integrity Manual for guidelines for related data analysis to identify inappropriate patterns of billing for consultations.

E - Clinical Laboratory Interpretation Services

Only clinical laboratory interpretation services listed below and which meet the criteria in subsections D.1, D.3, and D.4 for clinical consultations and, as a result, are billable under the fee schedule. These services are reported under the clinical laboratory code with modifier 26. These services can be paid under the physician fee schedule if they are furnished to a patient by a hospital pathologist or an independent laboratory. Note that a hospital's standing order policy can be used as a substitute for the individual request by the patient's attending physician. Carriers are not allowed to revise CMS's list to accommodate local medical practice. The CMS periodically reviews this list and adds or deletes clinical laboratory codes as warranted.

Clinical Laboratory Interpretation Services

Code	Definition
83020	Hemoglobin; electrophoresis
83912	Nucleic acid probe, with electrophoresis, with examination and report
84165	Protein, total, serum; electrophoretic fractionation and quantitation
84181	Protein; Western Blot with interpretation and report, blood or other body fluid
84182	Protein; Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification; each
85390	Fibrinolysin; screening
85576	Platelet; aggregation (in vitro), any agent
86255	Fluorescent antibody; screen
86256	Fluorescent antibody; titer
86320	Immunoelectrophoresis; serum, each specimen
86325	Immunoelectrophoresis; other fluids (e.g. urine) with concentration, each specimen
86327	Immunoelectrophoresis; crossed (2 dimensional assay)
86334	Immunofixation electrophoresis
87164	Dark field examination, any source (e.g. penile, vaginal, oral, skin); includes

Code	Definition
	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)

70 - Payment Conditions for Radiology Services

(Rev. 1, 10-01-03)

B3-15022

See Chapter 13 for claims processing instructions for radiology.

80 - Services of Physicians Furnished in Providers or to Patients of Providers

(Rev. 1, 10-01-03)

B3-15014

This section sets forth special conditions that govern payments for services that physicians furnish in, or to patients of, providers of services including hospitals, SNFs, or Comprehensive Outpatient Rehabilitation Facilities (CORFs). If physicians are compensated for their services by a provider or another entity, the compensation they receive must be allocated among the various types of services they furnish.

The FI pays for services that physicians furnish to the provider. Physician services to the provider include, but are not limited to, standby surgical services. Payment for physicians' services to individual patients that meet the conditions in subsection A is made under the physicians fee schedule. However:

- Payment for physicians' services furnished in teaching settings is subject to the additional conditions in §100;
- Payment for physicians' services furnished to ESRD patients is subject to additional requirements in Chapter 8, and

- The FI pays for the services of residents, as well as for physicians who are licensed to practice only in the provider setting, as provider services. (See §100.2)

A - Conditions for Physician Fee Schedule Payment for Physicians' Services to Patients in Providers

1 - General

Carriers pay for physicians' services to patients of providers on a fee schedule basis only if the following requirements are met:

- The services are personally furnished for an individual patient by a physician;
- The services contribute directly to the diagnosis or treatment of an individual patient;
- The services ordinarily require performance by a physician; and
- In the case of anesthesiology, radiology, or pathology/laboratory services, certain additional requirements in §§50, 60, and 70 are met.

2 - Services of Physicians to Patients in Providers

If a physician furnishes services to a patient in a hospital or SNF that do not meet the requirements in §80.A.1, above, but are related to patient care, the services may be covered as provider services and paid by the FI within the applicable Prospective Payment System (PPS) rate.

3 - Effect of Billing Charges for Physician Services to Provider

If services furnished by a physician to a provider may be paid by the FI, neither the provider nor the physician may seek fee schedule payments from the carrier, the beneficiary, or another insurer. Carriers must report any situation in which this happens to the RO unless it is clearly an isolated case of billing error.

4 - Effect of Assumption of Operating Costs

If a physician or an entity enters into an agreement (such as a lease or concession) with a provider under which the physician (or entity) assumes some or all of the operating costs of the provider department:

- Carriers make fee schedule payments only for physicians' services to individual patients;
- The physician (or other entity) must make its books and records available to the provider and the FI, as necessary, to verify the nature and extent of the costs of the services furnished by the physician (or other entity); and

- The lessee's costs associated with producing these services, including overhead, supplies, equipment, and the costs of employing nonphysician personnel are payable by the FI as provider services.

80.1 - Coverage of Physicians' Services Provided in Comprehensive Outpatient Rehabilitation Facility

(Rev. 1, 10-01-03)

B3-2220

Rehabilitation services furnished by comprehensive outpatient rehabilitation facilities (CORFs) are covered by Medicare Part B.

Under §1832(a)(2)(E), §1861(cc)(2), and related provisions of the Act, a CORF is recognized as a provider of services on the basis of its reasonable costs. Except for diagnostic and therapeutic services provided by physicians to individual patients, payment is made to the CORF by intermediaries (acting in the role of the Part B carrier.)

Physicians' diagnostic and therapeutic services furnished to a CORF patient are not considered CORF physician's services. Instead they are services that the physician must bill to the Part B carrier. If covered services, payment is made according to the Medicare Physician Fee Schedule. When physician's diagnostic and therapeutic services are furnished in a CORF, the claim must be annotated to show the CORF as the place of treatment.

Services considered administrative services provided by the physician associated with the CORF are considered CORF services reimbursable to the CORF by the FI. Administrative services include consultation with and medical supervision of nonphysician staff, establishing and reviewing the plan of treatment, and other medical and facility administration activities.

80.2 - Rural Health Clinic and Federally Qualified Health Center Services

(Rev. 1, 10-01-03)

B3-2260-2260.3

Payment may be made under Part B for the medical and other health services furnished by a qualified rural health clinic (RHC) and Federally qualified health centers (FQHCs). The covered services RHCs/FQHCs may offer are divided into two basic groups: RHC/FQHC services (defined below) and other medical and other health services covered under Part B.

Items and services which meet the definition of RHC services or FQHC services are reimbursed either by designated RHC intermediaries, or a national FQHC FI in the case

of independent RHCs/FQHCs, or by the provider's FI in the case of provider based clinics. In either case, the carrier does not pay claims for services defined as RHC/FQHC services. The FI pays for such services through a prospectively determined encounter rate.

Where an RHC or a FQHC is approved for billing other medical and health services to the carrier, the RHC or FQHC bills the carrier and is paid according to the method of payment for the service provided.

Rural health clinic and Federally qualified health center services are described in the Medicare Benefit Policy Manual, Chapter 13. That chapter provides that the following services usually performed by physicians are included as services included in the encounter rate and therefore are not separately billable for RHC/FQHC patients. They are:

- Professional services performed by a physician for a patient including diagnosis, therapy, surgery, and consultation (See the Medicare Benefit Policy Manual, Chapter 15);
- Services and supplies incident to a physician's services, as described in the Benefit Policy Manual, Chapter 15;
- Nurse practitioner and physician assistant services (including the services of specialized nurse practitioners and nurse midwives) that would be covered if furnished by a physician, provided the nurse practitioner or physician assistant is legally permitted to perform the services by the State in which they are performed;
- Services and supplies incident to the services of nurse practitioners and physician assistants that would be covered if furnished incident to a physician's services, and
- Visiting nurse services to the homebound.

However, the technical component of diagnostic services may be billed separately by the physician to the carrier, if provided. See Chapter 9, and the Medicare Benefit Policy Manual, Chapter 13, for additional information on the definition of RHC/FQHC services.

Also, an RHC or FQHC may provide other items and services which are covered under Part B, but which are not defined as RHC or FQHC services. They are listed in the Medicare Benefit Policy Manual, Chapter 13. Independent RHCs/FQHCs bill the carrier for such services. Provider-based RHC/FQHC services are billed to the FI as services of the parent provider.

Independent RHCs/FQHCs must enroll with the carrier in order to bill. (See the Medicare Program Integrity Manual, Chapter 10, for enrollment instructions).

80.3 - Unusual Travel (CPT Code 99082)

(Rev. 1, 10-01-03)

B3-15026

In general, travel has been incorporated in the MPFSDB individual fees and is thus not separately payable. Carriers must pay separately for unusual travel (CPT code 99082) only when the physician submits documentation to demonstrate that the travel was very unusual.

90 - Physicians Practicing in Special Settings

(Rev. 1, 10-01-03)

90.1 - Physicians in Federal Hospitals

(Rev. 1, 10-01-03)

B3-2020.5

There are many physicians performing services in hospitals operated by the Federal Government, e.g., military, Veterans Administration, and Public Health Service hospitals. Normally Medicare does not pay for the services provided by a physician in a Federal hospital except when the hospital provides services to the public generally as a community institution. Such a physician working in the scope of his Federal employment may be considered as coming within the statutory definition of physician even though he may not have a license to practice in the State in which he is employed.

90.2 - Physician Billing for End-Stage Renal Disease Services

(Rev. 1, 10-01-03)

See the Medicare Benefit Policy Manual, Chapter 11, for a description of ESRD policy.

See Chapter 8 for billing requirements for physicians and facilities.

90.2.1 - Inpatient Hospital Visits With Dialysis Patients

(Rev. 1, 10-01-03)

B3-15062-15062.1

Global billing practices that involve the submission of charges for each day that a patient is hospitalized are allowed. Therefore, carriers may make payment for inpatient hospital visits that are specified relative to time, place, day, and services directly provided to inpatients. This guideline may, however, differ with respect to daily visit charges for inpatient hospital visits with dialysis inpatients. When an ESRD patient is hospitalized,

the hospitalization may or may not be due to a renal-related condition. In either case, the patient must continue to be dialyzed.

Chapter 8 provides policy and payment instructions for physicians' services furnished to dialysis inpatients. It also provides instructions for billing physicians' renal-related medical services furnished on dialysis days and for dialysis and evaluation and management services performed on the same day.

90.3 - Physicians' Services Performed in Ambulatory Surgical Centers (ASC)

(Rev. 1, 10-01-03)

B3-2265, B3-2265.4

See Chapter 14, for a description of services that may be billed by an ASC and services separately billed by physicians.

The ASC payment does not include the professional services of the physician. These are billed separately by the physician. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patients' recovery from the anesthesia. The term physicians' services also includes any routine pre- or postoperative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services which the individual physician usually performs.

The physician must enter the place of service code (POS) 24 on the claim to show that the procedure was performed in an ASC.

The carrier pays the "facility" fee from the MPFSDB to the physician. The facility fee is for services done in a facility other than the physician's office and is less than the nonfacility fee for services performed in the physician's office.

90.4 - Billing and Payment in Health Professional Shortage Areas (HPSAs)

(Rev. 218, 06-25-04)

B3-3350, B3-15052

In accordance with §1833(m) of the Act, physicians who provide covered professional services in any rural or urban HPSA are entitled to an incentive payment. Beginning January 1, 1989, physicians providing services in certain classes of rural HPSAs were entitled to a 5-percent incentive payment. Effective January 1, 1991, physicians

providing services in either rural or urban HPSAs are eligible for a 10-percent incentive payment.

Eligibility for receiving the 10 percent bonus payment is based on whether the specific location at which the service is furnished is within an area that is designated (under section 332(a)(1)(A) of the Public Health Services Act) as a HPSA. The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating shortage areas.

HRSA designates three types of HPSAs: geographic, population and facility-based. Geographic-based HPSAs are areas with shortages of primary care physicians, dentists or psychiatrists. Population-based HPSAs are designations based on underserved populations within an area. Facility-based HPSAs are designations based on a public or non-profit private facility that is providing services to an underserved area or population and has an insufficient capacity to meet their needs.

Section 1833(m) of the Social Security Act (the Act) provides incentive payments for physicians who furnish services in areas designated as HPSAs under section 332 (a)(1)(A) of the Public Health Service (PHS) Act. This section of the PHS Act pertains to geographic-based HPSAs. Consequently, Medicare incentive payments are available only in geographic HPSAs.

Although section 1833(m) of the Act provides the authority to recognize the three types of geographic-based HPSAs (primary medical care, dental and mental health), only physicians, including psychiatrists, furnishing services in a primary medical care HPSA are eligible to receive bonus payments. In addition, effective for claims with dates of service on or after July 1, 2004, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. CMS does not recognize dental HPSAs for the bonus payment program.

It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although frequently this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital qualifies for the incentive payment as long as the specific location of the service is within an area designated as a HPSA. On the other hand, a physician may have an office in a HPSA but go outside the office (and the designated HPSA area)

to provide the service. In this case, the physician would not be eligible for the incentive payment. Carrier responsibilities include:

Informing the physician community of these provisions;

Detailing to interested physicians those locations which are HPSAs and the proper manner in which to code claims to qualify for the incentive payment;

Modifying the claims processing system to recognize and appropriately handle eligible claims;

Paying physicians the incentive payments; and

Performing post-payment reviews of samples of paid claims.

90.4.1 – Provider Education

(Rev. 218, 06-25-04)

B3-3350.1

Prior to 2005, at the time carriers are notified that an area has been classified (or declassified) as a HPSA, they inform the applicable physician community of the status of the area, the requirements for eligibility for the incentive payment, and the mechanism for claiming payment. To assure that all physicians understand these requirements, carriers publish a general summary bulletin on an annual basis.

Effective January 1, 2005, payment files for the automated payment of the HPSA bonus payment will be developed and updated annually. Once the annual designations are made, no interim changes will be made to the automated payment files to account for HPSA updates to designations throughout the year. New designations and withdrawals of HPSA designations during a calendar year will be included in the next annual update.

For newly designated HPSA areas, physicians will be able to receive the bonus by self-designating through the use of the QB or QU modifier. They will also need to submit the modifier for any designated areas not included in the automated file due to the cut off date of the data used. This will only be necessary if the zip code of where they provide their service is not already on the list of zip codes that will automatically receive the bonus payment. Physicians must not continue to self-designate through the use of the modifiers for HPSA designations that are withdrawn during the year, but are not part of the automated files.

Prior to the beginning of each calendar year beginning with 2005, CMS will post on its Web site zip codes that are eligible to automatically receive the bonus payment as well as information on how to determine when the modifier is needed to receive the bonus payment. Through regularly scheduled bulletins and list serves, carriers must notify all physicians to verify their zip code eligibility via the CMS Web site for the area where they provide physician services.

90.4.2 - HPSA Designations

(Rev. 218, 06-25-04)

B3-3350.2

HPSA designations are made by the Division of Shortage Designation (DSD) of the Public Health Service (PHS). *Prior to January 1, 2005*, upon receipt from DSD, CMS sends carriers individual notices of HPSA status changes (initial classification of HPSA areas or deletion of existing ones). Carriers must effectuate these changes as of the first day of the second month after carriers receive them. For example, any notice carriers receive during August is effective for physician services provided on or after October 1. Before effectuating these changes, carriers must ready the system for acceptance of the change and notify all physicians providing services in the impacted area who may be eligible for the incentive payment. Each quarter, CMS also provides carriers with an updated DSD comprehensive listing of all HPSAs in their jurisdiction. Carriers use this listing as a control to assure that all changes are accounted for and effectuated.

Although some HPSAs span entire counties (or other territorial subdivisions within a State), typically, they represent only sections of counties. For partial-county HPSAs, carriers prepare and distribute to physicians local maps which clearly delineate the HPSA areas. Carriers must notify physicians about HPSA areas by:

Publishing a list of HPSAs and allowing physicians to call carriers if they need assistance in determining whether their practice locale falls within the boundaries of a HPSA; and

Issuing maps of partial-county HPSAs that make it easier for physicians to determine if they provide services within designated HPSA areas.

Beginning with 2005, an automated file of designations will be updated on an annual basis and will be effective for services rendered with dates of service on or after January 1 of each calendar year beginning January 1, 2005, through December 31, 2005. Physicians will be allowed to self-designate throughout the year for newly designated HPSAs and HPSAs not included in the automated file based on the date of the data run used to create the file. The bonus will be effective for services rendered on or after the date of designation by HRSA. Designation letters and quarterly reports from HRSA will continue to be forwarded from the CMS Central Office to the Regional Offices to send to carriers. Carriers must continue to use them to update their lists of eligible HPSA areas as well as any other HRSA designation letters that may be provided to them by physicians.

The carriers and standard systems will be provided with a file at the appropriate time prior to the beginning of the calendar year for which it is effective. This file will contain zip codes that fully fall within a HPSA bonus area for both mental health and primary care services. After the implementation of this new process effective January 1, 2005, a recurring update notification will be issued for each annual update. Carriers will be informed of the availability of the file and the file name via an email notice.

Carriers will automatically pay bonuses for services rendered in zip code areas that fully fall within a designated primary care or mental health full county HPSA; are considered to fully fall in the county based on a determination of dominance made by the United States Postal Service (USPS); or are fully within a partial county HPSA area. Should a zip code fall within both a primary care and mental health HPSA, only one bonus will be paid on the service. Bonuses for mental health HPSAs will only be paid when performed by the provider specialty of 26 – psychiatry.

For services rendered in zip code areas that do not fall within a designated full county HPSA; are not considered to fall within the county based on a determination of dominance made by the USPS; are partially within a partial county HPSA; or are designated after the annual update is made to the automated file, physicians must still submit a QB or QU modifier to receive payment.

To determine whether a modifier is needed, physicians must review the information provided on the CMS Web site for HPSA designations to determine if the location where they render services is, indeed, within a HPSA bonus area. Physicians may also base the determinations on letters of designations received from HRSA. They must be prepared to provide these letters as documentation upon the request of the carrier and should verify the eligibility of their area for a bonus with their carrier before submitting services with a HPSA modifier.

For services rendered in zip code areas that cannot automatically receive the bonus, it will be necessary to know the census tract of the area to determine if a bonus should be paid and a modifier submitted. Census tract data can be retrieved by visiting the U.S. Census Bureau website at www.Census.gov. Once the Web site is accessed follow the following steps:

- 1. Click on American Fact Finder from the list on the left side of the screen.*
- 2. In the Search box on the left side of the screen, mark "geography" and enter "1990 census" and click GO.*
- 3. Click on "Show more selection methods and more geographic types."*
- 4. Click on the MAP tab.*

5. *Under "Select a year and program" select "1990 Decennial Census."*
6. *Under "Select an option, then click on the map" click on the "Select" button and from the drop down menu, select "Census Tract." DO NOT CLICK ON THE MAP.*
7. *Scroll down the page to: To reposition the map" and enter the address for which you want to determine the census tract.*
8. *The map will show the street and the census tract number will be in dark gold.*

Once the census tract is identified, the CMS Web site must be accessed to determine if the census tract where the service was rendered is in an eligible HPSA. Additional census tract information may be found on the Federal Financial Institutions Examination Council's website at www.ffiec.gov/geocode/default.htm. Neither CMS nor the Medicare carriers can provide information on the functionality of these websites.

Specific street addresses within a census tract may also be identified through the Census Tract Street Address Index (CTSAI) from:

Data User Services Division

Customer Service Branch

Bureau of the Census

Washington, D.C. 20233

90.4.3 - Claims Coding Requirements

(Rev. 218, 06-25-04)

B3-3350.3

For services with dates of service prior to January 1, 2005, physicians must indicate that their services were provided in an incentive-eligible rural or urban HPSA by using one of the following modifiers:

QB - physician providing a service in a rural HPSA; or

QU - physician providing a service in an urban HPSA.

For services with dates of service on or after January 1, 2005, the bonus will automatically be paid without the submission of a modifier for the following:

- When services are provided in a zip code area that fully falls within a full county HPSA.

- *When services are provided in a zip code area that partially falls within a full county HPSA and has been determined to be*

dominant for the county by the USPS.

- *When services are provided within a zip code that fully falls within a partial county HPSA.*

The submission of the QB or QU modifier will be required for the following:

When services are provided in zip code areas that do not fully fall within a designated full county HPSA bonus area.

When services are provided in a zip code area that partially falls within a full county HPSA but is not considered to be in that county based on the dominance decision made by the USPS.

When services are provided in a zip code area that partially falls within a partial county HPSA.

- *When services are provided in a zip code area that was not included in the automated file based on the date of the data run used to create the file.*

In order to be considered for the bonus payment, the name, address, and zip code of where the service was rendered must be included on all electronic and paper claims submissions.

90.4.4 - Payment

(Rev. 1, 10-01-03)

B3-3350.4

The incentive payment is 10 percent of the amount actually paid, **not** the approved amount. Carriers pay the incentive payment for services identified on either assigned or unassigned claims.

They do not include the incentive payment with each claim payment. Carriers should:

- Establish a quarterly schedule for issuing incentive payments. These payments are taxable and must be reported to the IRS.
- Prepare a list to accompany each payment. Include a line item for each assigned claim represented in the incentive check and a “summary” item showing the number of unassigned claims represented. The sum of the line items and the “summary” item should equal the amount of the check.

90.4.5 - Services Eligible for HPSA and Physician Scarcity Bonus Payments

(Rev. 218, 06-25-04)

B3-3350.5

A - Information in the Professional Component/Technical Component (PC/TC) Indicator Field of the Medicare Physician Fee Schedule Database

Carriers use the information in the Professional Component/Technical Component (PC/TC) indicator field of the Medicare Physician Fee Schedule Database to identify professional services eligible for HPSA *and physician scarcity* bonus payments. The following are the rules to apply in determining whether to pay the bonus on services furnished within a geographic HPSA *or physician scarcity bonus area*.

PC/TC Indicator	Bonus Payment Policy
0	Pay bonus
1	Globally billed. Only the professional component of this service qualifies for the bonus payment. The bonus cannot be paid on the technical component of globally billed services.

PC/TC Indicator	Bonus Payment Policy
	ACTION: <i>Carriers return the service as unprocessable and notify the physician that the professional component must be re-billed if it is performed within a qualifying bonus area.</i> If the technical component is the only component of the service that was performed in the <i>bonus area</i> , there wouldn't be a qualifying service.
1	Professional Component (modifier 26). Carriers pay the bonus.
1	Technical Component (modifier TC). Carriers do not pay the bonus.
2	Professional Component only. Carriers pay the bonus.
3	Technical Component only. Carriers do not pay the bonus.
4	Global test only. Only the professional component of this service qualifies for the bonus payment. ACTION: Carriers return the service as unprocessable. They instruct the provider to re-bill the service as separate professional and technical component procedure codes.
5	Incident to codes. Carriers do not pay the bonus.
6	Laboratory physician interpretation codes. Carriers pay the bonus.
7	Physical therapy service. Carriers do not pay the bonus.
8	Physician interpretation codes. Carriers pay the bonus.
9	Concept of PC/TC does not apply. Carriers do not pay the bonus.

NOTE: Codes that have a status of "X" on the Medicare Physician Fee Schedule Database (MFSDB) have been assigned PC/TC indicator 9 and are not considered physician services for MFSDB payment purposes. Therefore, *neither the HPSA bonus payment nor the physician scarcity area* will be paid for these codes.

B - Anesthesia Codes (CPT Codes 00100 Through 01999) That Do Not Appear on the MFSDDB

Anesthesia codes (CPT codes 00100 through 01999) do not appear on the MFSDDB. However, when a medically necessary anesthesia service is furnished within a HPSA *or physician scarcity* area by a physician, a HPSA bonus *and/or physician scarcity bonus is payable*.

To claim a *bonus* payment for anesthesia, physicians bill codes 00100 through 01999 with modifiers QY, QK, AD, AA, or GC to signify that the anesthesia service was performed by a physician *along with the QB or QU modifier when required per section 90.4.3*.

C – Mental Health Services

Physicians' professional mental health services rendered by the provider specialty of 26 – psychiatry, are eligible for a HPSA bonus when rendered in a mental health HPSA. The service must have a PC/TC designation per the chart above. Should a zip code fall within both a primary care and mental health HPSA, only one bonus must be paid on the service.

90.4.6 - Remittance Messages

(Rev. 218, 06-25-04)

B3-3350.6

Carriers use the following messages for services on which the HPSA/*physician scarcity* bonus is claimed.

A - Services Where the HPSA/*Physician Scarcity* Bonus Can Only Be Paid on a Portion of the Billed Service at the Service/Line Level

Claim adjustment reason code 16, "Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Line level remark code M73, "*The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components.* "

B - Services That Are Not Eligible for HPSA/*Physician Scarcity* Payments at the Service/Line Level

Line level remark code M74, “This service does not qualify for a HPSA/*Physician Scarcity* bonus payment.”

Note: This is an informational message only.

90.4.7 - Post-payment Review

(Rev. 218, 06-25-04)

B3-3350.7

Carriers should observe the guidelines below:

Each quarter, prepare a list of physicians who received incentive payments for the prior calendar quarter. *For claims with dates of service on or after January 1, 2005, carriers are only required to include services paid with the QB or QU modifier for post-pay HPSA review. They are not required to include services with bonuses that were automatically paid based on the zip code. However, at their discretion, carriers may perform any additional post-pay review that they feel is prudent related to services that received a HPSA bonus.*

Array them by the total amount of incentive payments received;

Select the 25 percent of physicians on the list who received the highest payments; and

Review a sample of five claims by each physician. If the physician provided services in a variety of settings (e.g., office, hospital, patient’s home), select sample claims representing different types of settings.

NOTE: After the first quarter of the year, carriers repeat the basic selection process in subsequent quarters; that is, review a 5-claim sample from the 25 percent of physicians who received incentive payments on an arrayed quarterly list. Skip physicians appearing higher on the list who were reviewed in an earlier quarter and were found to be in compliance. Carriers need not review a compliant physician for more than one quarter within the same calendar year. However, once a physician has claimed incentive payments erroneously, carriers continue monitoring the physician until he/she is in compliance.

Review the selected claims to verify that the place(s) of service shown was actually in a rural or urban HPSA.

Effective for claims with dates of service on or after July 1, 2004, review any mental health services selected as part of the 25% sample to verify that they were provided in a mental health HPSA by the physician specialty of 26, psychiatry.

Effective for claims with dates of service on or after January 1, 2005, use the designations on the HRSA Web site combined with the quarterly reports and HRSA letters to verify that the service was provided in a HPSA. Also accept designations

letters from HRSA that may be provided to you by physicians as appropriate documentation to determine HPSA areas eligible for the bonus payment.

- *Effective for claims with dates of service on or after January 1, 2005, use the date of the HPSA designation or withdrawal on the HRSA Web site or the date of designation or withdrawal in notification letters from HRSA as the effective date for paying the HPSA bonus.*

Should carriers find that any of the claims should not have been coded for the incentive payment, calculate and pursue the amount of any overpayment;

Contact the physician and his/her billing staff to resolve any discrepancies and correct any misunderstandings about the incentive program;

Refer unresolved discrepancies to the RO for possible sanction; and

Transmit findings via CROWD (Form 1565E) to central office no later than the 75th day following the close of the CROWD reporting quarter.

90.4.8 - Reporting

(Rev. 1, 10-01-03)

B3-3350.8, B3-13320, B3-13320.1, B3-13322.3

Reporting instructions are included in Chapter 6 of the Medicare Financial Management Manual.

90.4.9 - HPSA Incentive Payments for Physician Services Rendered in a Critical Access Hospital (CAH)

(Rev.)

90.4.10 – Administrative and Judicial Review

(Rev. 218, 06-25-04)

Per section 413(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, there shall be no administrative or judicial review respecting:

- *The identification of a county or area;*
- *The assignment of a specialty of any physician;*
- *The assignment of a physician to a county; or*
- *The assignment of a postal zip code to a county or other area.*

90.5 – Billing and Payment in a Physician Scarcity Area

(Rev.)

90.5.1 – Provider Education

(Rev.)

90.5.2 – Detailing Physician Scarcity Area Locations

(Rev.)

90.5.3 – Claims Coding Requirements

(Rev.)

90.5.4 – Payment

(Rev.)

90.5.5 – Services Eligible for the Physician Scarcity Bonus

(Rev.)



100 - Teaching Physician Services

(Rev. 1, 10-01-03)

B3-2020.7, B3-8201, B3-15016

A - General

Medical insurance covers the services attending physicians (other than interns and residents) render in the teaching setting to individual patients.

The following guidelines and instructions relate primarily to hospitals, but to the extent they are applicable, also govern payment for services of attending physicians supervising interns and residents in skilled nursing facilities.

Payment under the MPFSDB may be made for the professional services rendered to a beneficiary by his/her attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of the patient. In the case of major surgical procedures and other complex and dangerous procedures or situations, such personal direction must include supervision in person by the attending physician. A charge is recognized under Part B for the services of an attending physician who involves residents and interns in the care of his/her patient only if his/her services to the patient are of the same character, in terms of responsibilities to the patient that are assumed and fulfilled, as the service he/she renders to other paying patients.

The carrying out by the physician of these responsibilities is demonstrated by such actions as:

- Reviewing the patient's history and physical examination;
- Personally examining the patient within a reasonable period after admission;
- Confirming or revising diagnosis;
- Determining the course of treatment to be followed;
- Assuring that any supervision needed by the interns and residents was furnished;
and
- By making frequent review of the patient's progress.

As evidence that a covered service was rendered by the supervisory physician, the medical record must contain signed or countersigned notes by the supervisory physician that show he/she personally reviewed the patients medical history, gave a physical examination, confirmed or revised the diagnosis, visited the patient during the more critical period of the illness, and discharged the patient. For all other individual occasions of service billed, notes in the medical record by interns, residents, or nurses

which indicate that the physician was physically present when the service was rendered are sufficient documentation of the physician's involvement.

B - Definitions

For purposes of this section, the following definitions apply.

Resident - An individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the FI.

The fact that an individual hospital does not choose to include an eligible individual in its full-time equivalency count of residents does not change that individual's status as a resident in an approved GME program.

A medical student is never considered to be a resident. Any contribution of a medical student to the performance of a service or billable procedure (other than the taking of a history in the case of an E/M service) must be performed in the physical presence of a physician or jointly with a resident in a service meeting the requirements set forth below for teaching physician billing.

Teaching Physician - A physician (other than another resident) who involves residents in the care of his or her patients.

Direct Medical and Surgical Services - Services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital making the reasonable cost election for physician services furnished in teaching hospitals. All payments for such services are made by the FI for the hospital.

Teaching Hospital - A hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

Teaching Setting - Any provider, hospital-based provider, or nonprovider setting in which Medicare payment for the services of residents is made by the FI under the direct graduate medical education payment methodology or freestanding SNF or HHA in which such payments are made on a reasonable cost basis.

100.1 - Payment for Physician Services in Teaching Settings Under the MPFS

(Rev. 1, 10-01-03)

Payment is made for physician services furnished in teaching settings under the physician fee schedule only if the teaching physician is present during the key portion of the service for which payment is sought, and either:

- The services are personally furnished by a physician who is not a resident; or
- The services are furnished jointly by a teaching physician and resident or by a resident in the presence of a teaching physician with certain exceptions as provided below.

In both situations, the services of the resident are payable to the hospital through the FI.

100.1.1 - Evaluation and Management (E/M) Services

(Rev. 1, 10-01-03)

For a given encounter, the selection of the appropriate level of E/M service should be based on “Documentation Guidelines for Evaluation and Management Services” developed by the American Medical Association (AMA) and CMS and published by the AMA. Carriers publish guidelines based on the combination of this document and the CPT book. If a teaching physician documents his or her presence and participation in the E/M service, the level of service may be selected based on the extent of history and/or examination and/or the complexity of the medical decision making required by the patient and documented in his or her personal entry in the medical record which may include references to notes entered by the resident.

Except as indicated in subsection C, the teaching physician must be physically present during the portion of the service that determines the level of service billed. In all cases, the teaching physician must personally document his/her presence and participation in the services in the medical records. This documentation by the teaching physician may be either in writing or via a dictated note and expressed in the following ways for these major categories of E/M service.

A - Initial Hospital Care, Emergency Department Visits, Office Visits for New Patients, Office Consultations, and Hospital Consultations

A personal notation must be entered by the teaching physician documenting his or her participation in the three key components of these services (i.e., history, examination, and medical decision making) as required by CPT and demonstrating the appropriate level of service required by the patient. If the teaching physician is repeating key elements of the service components obtained previously and documented by the resident, e.g., the patient’s complete history and physical examination, the teaching physician need not repeat the documentation of these components in detail. Rather, the documentation of the teaching physician may be brief, summary comments that relate to the resident’s entry and which confirm or revise the key elements defined for the purpose of this section as:

- Relevant history of present illness and prior diagnostic tests;
- Major finding(s) of the physical examination;
- Assessment, clinical impression, or diagnosis; and

- Plan of care.

Therefore, the documentation of the key elements above may be satisfied by combining entries into the medical record made by the resident and the teaching physician. The documentation requirements for some common clinical situations for teaching physicians are illustrated below.

Illustration 1

All required elements are obtained personally by the teaching physician without a resident present. In this situation, a resident may or may not have performed an independent service. If no resident has seen the patient, the physician should document on the same basis he or she would document an E/M service in a nonteaching setting. If a teaching physician's service follows a resident's service, then the teaching physician's documentation should refer to the resident's note and provide summary comments that establish, revise, or confirm the resident's findings and the appropriate level of service required by the patient. For example, the teaching physician would not have to restate the review of systems and family social history in the case of an initial hospital service. However, the teaching physician would have to examine and question the beneficiary to verify the key findings of the resident's notes since he or she was not present during the resident's interaction with the beneficiary.

Illustration 2

All required elements are obtained by the resident in the presence of, or jointly with, the teaching physician and documented by the resident. In this situation, the resident's note may document the teaching physician's direct observation, performance, and personal input into the key elements. The teaching physician's personal documentation may be limited. At a minimum, it must include a confirmation of each component of the resident's documentation and the teaching physician's presence during the service. The combination of entries must be adequate to substantiate the level of service required by the patient.

Illustration 3

Selected required elements of the service, for example, history and physical examination are obtained by the resident independently. The teaching physician repeats the key elements of the examination. These elements are discussed with the resident either prior to or after the teaching physician's personal service. In this situation, the resident's note may document the teaching physician's input into the history and medical decision making. The teaching physician's note must include summary comments that revise or confirm the findings of the resident's physical examination and discussion of the history and medical decision making. The combined entries must be adequate to substantiate the level of service required by the patient and billed.

B - Subsequent Hospital Care and Office Visits for Established Patient

A personal notation by the teaching physician must be entered highlighting two of the three key components of these services (i.e., history, physical examination, and medical decision making). The same guidelines set forth in subsection a are required for follow-up visits for established patients.

For E/M codes that are selected on the basis of time, see §100.1.4.

C - Exception for E/M Services Furnished in Certain Primary Care Centers

For the E/M codes listed below, carriers pay teaching physician claims for services furnished by residents without the presence of a teaching physician. When a GME program is granted the primary care exception, it applies to the following lower and mid-level E/M services:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

For this exception to apply, a center must attest in writing that all of the following conditions are met for a particular residency program. A center does not have to be approved in advance. Maintain a file of such attestations for later use in the case of questionable future claims for payment.

The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's FI. This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a nonhospital entity, verify with the FI that the entity meets the requirements of a written agreement between the hospital and the entity set forth in 42 CFR 413.86(f)(1)(iii).

Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program. If it becomes necessary to verify this information, teaching hospitals are required to maintain such information under the provisions of 42 CFR 413.86(f)(2).

The teaching physician in whose name the payment is sought must not supervise more than 4 residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:

- Have no other responsibilities (including the supervision of other personnel) at the time of the service for which payment is sought;

- Assume management responsibility for those beneficiaries seen by the residents;
- Ensure that the services furnished are appropriate;
- Review with each resident during or immediately after each visit the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies; and
- Document the extent of his or her own participation in the review and direction of the services furnished to each beneficiary.

The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians. The residents must generally follow the same group of patients throughout the course of their residency program, but there is no requirement that the teaching physicians remain the same over any period of time.

The range of services furnished by residents includes all of the following:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- Coordination of care furnished by other physicians and providers; and
- Comprehensive care not limited by organ system or diagnosis.

The types of residency programs most likely to qualify for the primary care exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.

100.1.2 - Surgical Procedures

(Rev. 1, 10-01-03)

In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

A - Surgery (Including Endoscopic Operations)

The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be key or critical portions of the procedure. The teaching surgeon may determine which postoperative visits are considered key and require his or her presence. However, if the postoperative period extends beyond the beneficiary's discharge and the teaching surgeon is not going to be involved in the beneficiary's follow-up care, the instructions on billing for less than the global package in §40 apply. During the period in which the teaching surgeon does not have to be physically present, he or she must remain immediately available to return to the procedure, i.e., he or she must not be involved in another procedure from which he or she cannot return. If the teaching physician is not immediately available, he or she must arrange for another physician to be immediately available to intervene in the original case should the need arise in order to bill for the original procedure. The designee is a physician who is not involved in or immediately available for any other surgical procedure. The CMS is not defining availability in terms of geographic location vis-à-vis the operating room.

1 - Single Surgery

When the teaching surgeon is present for the entire period between the opening and closing of the surgical field, his or her presence may be demonstrated by notes in the medical records made by the physician, resident, or operating room nurse. For purposes of this teaching physician policy, there is no required information that the teaching surgeon must enter into the medical records.

2 - Two Overlapping Surgeries

In order to bill for two overlapping surgeries, the teaching surgeon must be present during the key portions of both operations. Therefore, the key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document the key portion of both procedures in his or her notes in order that a reviewer may clearly infer that the teaching physician was immediately available to return to either procedure in the event of complications. If the teaching physician leaves the operating room after the key portion(s) of the surgical procedure or during the closing of the surgical field to become involved in another surgical procedure, he or she must arrange for another physician to be immediately available to intervene in the original case should the need arise in order to bill for the original procedure. In the case of three concurrent surgical procedures, the role of the teaching **surgeon** (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual beneficiary and is not payable under the physician fee schedule.

3 - Minor Procedures

For procedures that take only a few minutes (five minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

4 - Anesthesia

An unreduced fee schedule payment is made if a teaching anesthesiologist is involved in a procedure with one resident. The teaching physician must document in the medical records that he or she was present during all critical (or key) portions of the procedure including induction and emergence. The teaching physician's presence is not required during the preoperative or postoperative visits with the beneficiary. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a nonphysician anesthetist, pay for the anesthesiologist's services as medical direction.

5 - Endoscopy Procedures

In order to bill for procedures performed through an endoscope (other than endoscopic operations that follow the surgery policy in subsection a), the teaching physician must be present during the entire viewing. The entire viewing includes insertion and removal of the device. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

100.1.3 - Psychiatry

(Rev. 1, 10-01-03)

For psychiatric services furnished under an approved GME program, the requirement for the presence of the teaching physician during the service may be met by concurrent observation of the service by use of a one-way mirror or video equipment. Audio-only equipment does not satisfy to the physical presence requirement. In the case of time-based services such as individual medical psychotherapy, see §100.1.4, below. Further, the teaching physician supervising the resident must be a physician, i.e., the Medicare teaching physician policy does not apply to psychologists who supervise psychiatry residents in approved GME programs.

100.1.4 - Time-Based Codes

(Rev. 1, 10-01-03)

For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service of from 20 to 30 minutes may be paid only if the teaching physician is physically present for 20 to 30 minutes. Even if the resident is with the teaching physician when the time is spent with the beneficiary or if time is spent by the

teaching physician alone with the beneficiary a claim may be submitted. Examples of codes falling into this category include:

- Individual medical psychotherapy (HCPCS codes 90809 - 90829);
- Critical care services (CPT codes 99291-99292);
- Hospital discharge day management (CPT codes 99238-99239);
- E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service;
- Prolonged services (CPT codes 99354-99359); and
- Care plan oversight (HCPCS codes G0181 - G0182).

100.1.5 - Other Complex or High-Risk Procedures

(Rev. 1, 10-01-03)

In the case of complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician, pay for the physician services associated with the procedure only when the teaching physician is present with the resident. The presence of the resident alone would not establish a basis for fee schedule payment for such services. These procedures include interventional radiologic and cardiologic supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and trans-esophageal echocardiography.

100.1.6 - Miscellaneous

(Rev. 1, 10-01-03)

In the case of maternity services furnished to women who are eligible for Medicare, apply the physician presence requirement for both types of delivery as carriers would for surgery. In order to bill for the procedure, the teaching physician must be present for the delivery. These procedure codes are somewhat different from other surgery codes in that there are separate codes for global obstetrical care (prepartum, delivery, and postpartum) and for deliveries only. In situations in which the teaching physician's only involvement was at the time of delivery, the teaching physician should bill the delivery only code. In order to bill for the global procedures, the teaching physician must be present for the minimum indicated number of visits when such a number is specified in the description of the code. This policy differs from the policy on general surgical procedures under which the teaching physician is not required to be present for a specified number of visits.

Carriers do not apply the physician presence policy to renal dialysis services of physicians who are paid under the physician monthly capitation payment method.

100.1.7 - Assistants at Surgery in Teaching Hospitals

(Rev. 1, 10-01-03)

B3-15016.D

A - General

Carriers do not pay for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service unless the requirements of one of subsections C, D, or E are met. Each teaching hospital has a different situation concerning numbers of residents, qualifications of residents, duties of residents, and types of surgeries performed.

The FI should provide the carrier with a list of teaching physicians and hospitals. There may be some teaching hospitals in which carriers can apply a presumption about the availability of a qualified resident in a training program related to the medical specialty required for the surgical procedures, but there are other teaching hospitals in which there are often no qualified residents available. This may be due to their involvement in other activities, complexity of the surgery, numbers of residents in the program, or other valid reasons. Carriers process assistant at surgery claims for services furnished in teaching hospitals on the basis of the following certification by the assistant, or through the use of modifier -82 which indicates that a qualified resident surgeon was not available. This certification is for use only when the basis for payment is the unavailability of qualified residents.

I understand that §1842(b)(7)(D) of the Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier.

Carriers retain the claim and certification for four years and conduct post-payment reviews as necessary. For example, carriers investigate situations in which it is always certified that there are no qualified residents available, and undertake recovery if warranted.

Assistant at surgery claims denied based on these instructions do not qualify for payment under the limitation on liability provision.

B - Definition

An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service.

C - Exceptional Circumstances

Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §20.4.3 notwithstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances, e.g., emergency, life-threatening situations such as multiple traumatic injuries which require immediate treatment. There may be other situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

D - Physicians Who Do Not Involve Residents in Patient Care

Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the limitations in §20.4.3, above, if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients. Generally, this exception is applied to community physicians who have no involvement in the hospital's GME program. In such situations, payment may be made for reasonable and necessary services on the same basis as would be the case in a nonteaching hospital. However, if the assistant is not a physician primarily engaged in the field of surgery, no payment be made unless either of the criteria of subsection E is met.

E - Multiple Physician Specialties Involved in Surgery

Complex medical procedures, including multistage transplant surgery and coronary bypass, may require a team of physicians. In these situations, each of the physicians performs a unique, discrete function requiring special skills integral to the total procedure. Each physician is engaged in a level of activity different from assisting the surgeon in charge of the case. The special payment limitation in §20.4.3 is not applied. If payment is made on the basis of a single team fee, additional claims are denied. The carrier will determine which procedures performed in the service area require a team approach to surgery. Team surgery is paid for on a "By Report" basis.

The services of physicians of different specialties may be necessary during surgery when each specialist is required to play an active role in the patient's treatment because of the existence of more than one medical condition requiring diverse, specialized medical services. For example, a patient's cardiac condition may require the a cardiologist be present to monitor the patient's condition during abdominal surgery. In this type of situation, the physician furnishing the concurrent care is functioning at a different level than that of an assistant at surgery, and payment is made on a regular fee schedule basis.

100.1.8 - Physician Billing in the Teaching Setting

(Rev. 1, 10-01-03)

B3-8204, B3-15016

A - Reimbursement to the Hospital

When a hospital is billing the carrier, as opposed to the physician billing the carrier, for covered services, it must bill the carrier on the Form CMS-1500 or equivalent electronic format. It no longer has the option to establish any other type of agreement with the carrier.

B - Carrier Claims

The method by which services performed in a teaching setting must be billed is determined by the manner in which reimbursement is made for such services. For carriers, the shared system suspends claims submitted by a teaching physician, for review.

100.2 - Interns and Residents

(Rev. 1, 10-01-03)

B3-2020.8, B3-8030

An attending physician's services to beneficiaries in a teaching setting are covered under the supplementary medical insurance program. Many physicians rendering such services are on the faculty of a medical school or have arrangements with providers to supervise and teach interns and residents. Payment may be made for professional services to a beneficiary by an "attending" physician where the attending physician provides personal identifiable direction to interns or residents who are participating in the care of this patient.

See the Medicare Benefit Policy Manual, Chapter 15, for services furnished by interns and residents within and outside the scope of an approved training program.

110 - Physician Assistant (PA) Services Payment Methodology

(Rev. 1, 10-01-03)

B3-16001, B3-2156, B3-15004, B3-4112, B3-15024

See the Medicare Benefit Policy Manual, Chapter 15, for coverage policy for physician's assistant (PA) services.

Physician Assistant services are paid at the lesser of the actual charge or 85 percent of the physician fee schedule, except covered PA assistant at surgery services (described below) and services performed in a hospital.

For services performed in a hospital, carriers limit the payment to 75 percent of the fee schedule amount or the lesser of the actual charge for the service. This payment limit applies to a PA in a hospital or in a rural HPSA.

The AS modifier must be on claim for assistant at surgery claims.

110.1 - Limitations for Assistant-at-Surgery Services

(Rev. 1, 10-01-03)

B3-16001

The carrier shall pay covered PA assistant at surgery services at 85 percent of the 16 percent of the physician fee schedule amount (i.e., 10.4 percent).

Carriers must assure that there is no duplication of payment for surgical services. When surgery is paid on a global charge basis, including a specified number of days of postoperative care, any postoperative services billed for the PA during this period of time are paid only when the physician's global fee for surgery has been reduced to reflect that the services covered under the procedure code have been reduced or eliminated.

110.2 - Outpatient Mental Health Limitation

(Rev. 1, 10-01-03)

B3-4112, B3-2472.4

The carrier must apply the outpatient mental health limitation to all covered mental health therapeutic services furnished by PAs. The reduction is 62.5 percent applied after the 85 percent.

Refer to §210 below for a complete discussion of the outpatient mental health limitation.

110.3 - PA Billing to Carrier

(Rev. 1, 10-01-03)

B3-16001, B3-15044, B3-2156, PM-B-99-16

A - Modifiers

Physician Assistant as assistant at surgery should be identified with a modifier AS. Billers must identify PA assistant-at-surgery services with the following modifiers as applicable:

- Assistant surgeon services billed with modifier “-80”;
- Minimum assistant surgeon services with modifier “-81”;
- Assistant surgeon services (when assistant resident surgeon not available) with modifier 82.

NOTE: 80, 81, and 82 are paid at 65 percent of 16 percent. No other reductions for minimum services take place.

HPSA modifiers shall be used on PA claims for HPSA areas (modifiers QB and QU).

B - PA Identification

PAs must have their own “practitioners” provider identification number (PIN). Specialty code 97 applies.

C - Assignment Requirement

(Rev. 1, 10-01-03)

B3-17000, B3-3040.4

A PA like a NP may bill using their own provider number. All claims for PA services must be made on an assignment basis. If any person or entity (employer or PA) knowingly and willfully bills the beneficiary an amount in excess of the appropriate coinsurance and deductible, the responsible party is subject to a civil monetary penalty not to exceed \$2,000 for each such bill or request for payment.

120 - Nurse Practitioner (NP) And Clinical Nurse Specialist (CNS) Services

(Rev. 1, 10-01-03)

B3-16002, B3-2158-2160

See the Medicare Benefit Policy Manual Chapter 15, for coverage policy.

A - General Payment

In general, NPs and CNSs are paid for covered services at 85 percent of the Medicare Physician Fee Schedule.

B - Mental Health Limitation

(Rev. 1, 10-01-03)

B3-4112, B3-2472-2472.4

The carrier must apply the outpatient mental health limitation to all covered mental health therapeutic services furnished by NPs and CNSs. The reduction is 62.5 percent applied after the 85 percent.

Refer to §210, below, for a discussion of the outpatient mental health limitation.

120.1 - Direct Billing and Payment

(Rev. 1, 10-01-03)

B3-2158.E, B3-2160.E, 3040.4

Prior to January 1, 1998, direct billing and payment for NP services was available only in limited circumstances, as follows:

- Payment for services furnished in SNFs or NFs in urban areas was made to the NP's employer; and
- Payment for services furnished in all settings in rural areas was made to the NP or to his/her employee or contractor.

Effective January 1, 1998, restrictions were removed on the type of areas and settings in which the professional services of NPs and CNSs are paid for by Medicare.

- Payments are allowed for services furnished by them in all areas and settings permitted under applicable state licensure laws.
- Payment may be made to the NP or CNS or to the employer or contractor.

NPs services are paid only on an assignment basis.

However, even though an independent NP or CNS would otherwise bill directly for such services, NP or CNS services provided in a hospital setting must be billed by the facility. This is because the law authorizing coverage of such services did not also authorize their unbundling from the rest of the hospital bill. Therefore, only the hospital, and not the practitioner, may bill.

NPs are identified on the provider file with specialty code 50 and provider type 38. CNSs are identified on the provider file by specialty 89 and provider type 38.

130 - Nurse-Midwife Services

(Rev. 1, 10-01-03)

B3-16004, 5257

See the Medicare Benefit Policy Manual, Chapter 15, for coverage policy for nurse-midwife services.

130.1 - Payment for Services

(Rev. 1, 10-01-03)

B3-16004.A, B3-16004.B, B3-5257.B, B3-3040.4, B3-17001.1

Billing does not have to flow through a physician or facility.

Payment for most nurse-midwife services is based on equal to 65 percent of the physician fee schedule. However, covered drugs furnished by nurse midwives are paid according to the drug payment methodology. Covered clinical diagnostic lab services are paid according to the clinical diagnostic lab fee schedule. Note that clinical lab is not subject to deductible and coinsurance

The NMW limitation is applied to the Medicare allowed amount after application of the outpatient mental health limit. As of January 1, 1998, however, restrictions were lifted requiring payments be made to employers and contractors for services provided in SFS or NFS in urban areas and in all settings in rural areas. Payments can now be directly made for outpatient mental health services in all areas and settings as permitted under applicable state licensure laws. Refer to §210 below for a discussion of the outpatient mental health limitation.

Payment is made only on an assigned basis.

NMWs are identified by specialty 42.

130.2 - Global Allowances

(Rev. 1, 10-01-03)

B3-16004.C, B3-5257.C

When a nurse-midwife is providing care to a Medicare beneficiary and the collaborating physician provides some of the services, the fee paid to the nurse-midwife is based on the portion of the global fee that would have been paid to the physician for the service provided by the nurse-midwife.

For example, a nurse-midwife requests that the physician examine the beneficiary, per their collaborative agreement, prior to the delivery. The nurse-midwife has provided the

ante partum care and intends to perform the delivery and post partum care. The physician fee schedule amount for the physician's total obstetrical care (global fee) is \$1,000. The physician fee schedule amount for the physician's office visit is \$30. The following calculation shows the maximum allowance for the nurse-midwife's service:

Physician fee schedule amount for total obstetrical care	\$1,000.00
Physician fee schedule amount for visit	- 30.00
Result	\$ 970.00
Fee schedule amount for nurse-midwife (65% x \$970)	\$ 630.50

Therefore, the nurse-midwife would be paid no more than 80 percent of \$630.50 for the care of the beneficiary.

This calculation also applies when a physician provides most of the services and calls in a nurse-midwife to provide a portion of the care.

Physicians and nurse midwives use reduced service modifiers to report that they have not provided all the services covered by the global allowance.

140 - Certified Registered Nurse Anesthetist (CRNA) Services

(Rev. 1, 10-01-03)

B3-16003, B3-16003 A, B3-3040.4, B3-4172

Section 9320 of OBRA 1986 provides for payment under a fee schedule to certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs). CRNAs and AAs may bill Medicare directly for their services or have payment made to an employer or an entity under which they have a contract. This could be a hospital, physician or ASC. This provision is effective for services rendered on or after January 1, 1989.

Anesthesia services are subject to the usual Part B coinsurance and deductible and when furnished on or after January 1, 1992 by a qualified nurse anesthetist and are paid at the lesser of the actual charge, the physician fee schedule, or the CRNA fee schedule. Payment for CRNA services is made only on an assignment basis.

140.1 - Qualified Anesthetists

(Rev. 1, 10-01-03)

B3-16003.B, B3-4172.1

For payment purposes, CRNAs include both qualified anesthetists and AAs. Thus, the term CRNA will be used to refer to both categories of qualified anesthesiologists unless it is necessary to separately discuss these provider groups.

An AA is a person who:

- Is permitted by State law to administer anesthesia; and who
- Has successfully completed a six-year program for AAs of which two years consist of specialized academic and clinical training in anesthesia.

In contrast, a CRNA is a registered nurse who is licensed by the State in which the nurse practices and who:

- Is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists, or
- Has graduated within the past 18 months from a nurse anesthesia program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

140.1.1 - Issuance of UPINs

(Rev. 1, 10-01-03)

B3-4172.2

The CMS will provide a current list of all CRNAs in the carrier State who are certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. Carriers will check this list of certified CRNAs to document and confirm that applicants are properly qualified. When the applicant begins to bill, the carrier will provide written notice that continued billing privileges are dependent upon continued certification.

An employer of a group of CRNAs, e.g., a hospital, physician, or ASC may apply for a single PIN to cover all of the certified CRNAs in their employ. At the time of application, the employer must send a list of the names of all CRNAs for whom billing will be submitted. Carriers must then verify the certification status of the individuals on the list submitted by the employer. Carriers provide written notice to the employer of the names of the CRNAs it may bill for and require a statement from the employer certifying that it will bill only for those CRNAs who have been determined to be properly qualified. The employer must also agree to notify the carrier immediately if a CRNA leaves its employ or to seek authorization to bill for a new CRNA employee.

In the event an applicant for a billing number is not on the certification list provided by CMS, a notarized copy of the applicant's certification card issued by either of the Councils discussed above can be accepted. This may be necessary in situations where a CRNA has recently moved to a different State. The CMS will also provide carriers with a list of AAs eligible under this provision. The carrier must check this list to verify the presence of the applicant's name before issuing a billing number. In the event the applicant's name is not on this list, the carrier requires a notarized copy of the

individual's diploma and other information deemed pertinent in order to verify the applicant's status.

140.1.2 - Annual Review of CRNA Certifications

(Rev. 1, 10-01-03)

B3-4172.3

Carriers will review their files in November of each year to determine that the credentials of each CRNA continue to be valid. The CMS will provide an updated list of certified CRNAs each October.

The billing privileges of any CRNA or qualified biller will be terminated if the CRNA's certification has expired or otherwise been terminated by the certifying councils. Carriers will provide advance written notice to the CRNA (and employer) of any such decision and provide for a review of the action if requested to do so.

140.2 - Entity or Individual to Whom CRNA Fee Schedule is Payable

(Rev. 1, 10-01-03)

B3-16003.C, B3-4830.A

Payment for the services of a CRNA may be made to the CRNA who furnished the anesthesia services or to a hospital, physician, group practice, or ASC with which the CRNA has an employment or contractual relationship.

140.3 - CRNA Fee Schedule Payment

(Rev. 1, 10-01-03)

B3-16003 D and E

Pay for the services of a CRNA only on an assignment basis. The assignment agreed to by the CRNA is binding upon any other person or entity claiming payment for the service. Except for deductible and coinsurance amounts, any person who knowingly and willfully presents or causes to be presented to a Medicare beneficiary a bill or request for payment for services of a CRNA for which payment may be made on an assignment-related basis is subject to civil monetary penalties.

Services furnished by CRNAs are subject to the Part B deductible and coinsurance. If the Part B deductible has been satisfied, the CRNA fee schedule for anesthesia services is the least of 80 percent of:

- The actual charge;

- The applicable CRNA conversion factor multiplied by the sum of allowable base and time units; or
- The applicable locality participating anesthesiologist's conversion factor multiplied by the sum of allowable base and time units.

140.3.1 - CRNA Conversion Factors Used on or After January 1, 1997

(Rev. 1, 10-01-03)

B3-16003.F

The CRNA conversion factors applicable to anesthesia services furnished on or after January 1, 1997, are increased by the update factor used to update physicians' services under the physician fee schedule. They are published in November of the year preceding the year in which they apply.

140.3.2 - Anesthesia Time and Calculation of Anesthesia Time Units

(Rev. 1, 10-01-03)

B3-15018.G

Anesthesia time means the time during which a CRNA is present with the patient. It starts when the CRNA begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the CRNA is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished on or after January 1, 2000, the CRNA can add blocks of time around an interruption in anesthesia time as long as the CRNA is furnishing continuous anesthesia care within the time periods around the interruption.

140.3.3 - Billing Modifiers

(Rev. 1, 10-01-03)

The following modifiers are used when billing for anesthesia services:

- QX - CRNA with medical direction by a physician.
- QZ - CRNA without medical direction by a physician.
- QS - Monitored anesthesiology care services (can be billed by a CRNA or a physician).

- QY - Medical direction of one CRNA by an anesthesiologist. This modifier is effective for anesthesia services furnished by a CRNA (or AA) on or after January 1, 1998.

140.3.4 - General Billing Instructions

(Rev. 1, 10-01-03)

B3-4172.5

Claims for reimbursement for CRNA services should be completed in accord with existing billing instructions for anesthesiologists with the following additions.

- All claim forms must include the following certification, as applicable
 - “CRNA or AA services have been medically directed,” (indicate “A” in field 41, location I05 of Claim Detail I on an EMC bill), or;
 - “CRNA or AA services have not been medically directed,” (indicate “B” in field 41, location I05 of Claim Detail I on an EMC bill).
- If an employer-physician furnishes concurrent medical direction for a procedure involving CRNAs and the medical direction service is unassigned, the physician should bill on an assigned basis on a separate claim for the CRNA service. If the physician is participating or takes assignment, both services should be billed on one claim but as separate line items.
- All claims forms must have the provider billing number of the CRNA, AA and/or the employer of the CRNA performing the service in either block 24.H of the Form CMS-1500 and/or block 31 as applicable. Verify that the billing number is valid before making payment.

Payments should be calculated in accordance with Medicare payment rules in §140.3. Carriers must institute all necessary payment edits to assure that duplicate payments are not made to physicians for CRNA or AA services or to a CRNA or AA directly for bills submitted on their behalf by qualified billers.

CRNAs are identified on the provider file by specialty code 43.

140.4 - CRNA Special Billing and Payment Situations

(Rev. 1, 10-01-03)

140.4.1 - An Anesthesiologist and CRNA Work Together

(Rev. 1, 10-01-03)

Carriers will distribute educational releases and use other established means to ensure that anesthesiologists understand the requirements for medical direction of CRNAs.

Carriers will perform reviews of payments for anesthesiology services to identify situations in which an excessive number of concurrent anesthesiology services may have been performed. They will use peer practice and their experience in developing review criteria. They will also periodically review a sample of claims for medical direction of four or fewer concurrent anesthesia procedures. During this process physicians may be requested to submit documentation of the names of procedures performed and the names of the anesthesiologists directed.

Physicians who cannot supply the necessary documentation for the sample claims must submit documentation with all subsequent claims before payment will be made.

140.4.2 - CRNA and an Anesthesiologist in a Single Anesthesia Procedure

(Rev. 1, 10-01-03)

B3-4172.6

Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed CRNA, and the service is furnished on or after January 1, 1998, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone. The modifier to be used for current procedure identification is QX.

Beginning on or after January 1, 1998, where the CRNA and the anesthesiologist are involved in a single anesthesia case, and the physician is performing medical direction, the service is billed in accordance with the following procedures:

- For the single medically directed service, the physician will use the modifier “QY” (MEDICAL DIRECTION ONE CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) BY AN ANESTHESIOLOGIST). This modifier is effective for claims for dates of service on or after January 1, 1998, and
- For the anesthesia service furnished by the medically directed CRNA, the CRNA will use the current modifier “QX.”

In unusual circumstances when it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. The physician would report using the “AA” modifier and the CRNA would use “QZ,” or the modifier for a nonmedically directed case.

Documentation must be submitted by each provider to support payment of the full fee.

140.4.3 - Payment for Medical or Surgical Services Furnished by CRNAs

(Rev. 1, 10-01-03)

B3-16003.H

Payment can be made for medical or surgical services furnished by nonmedically directed CRNAs if they are allowed to furnish these services under State law. These services may include the insertion of Swan Ganz catheters, central venous pressure lines, pain management, emergency intubation, and the pre-anesthetic examination and evaluation of a patient who does not undergo surgery. Payment is determined under the physician fee schedule on the basis of the national physician fee schedule conversion factor, the geographic adjustment factor, and the resource-based relative value units for the medical or surgical service.

140.4.4 - Conversion Factors for Anesthesia Services of CRNAs Furnished on or After January 1, 1992

(Rev. 1, 10-01-03)

B3-16003.I, PM B-01-69

Conversion factors used to determine CRNA fee schedule payments for anesthesia services furnished on or after January 1, 1992, are determined based on a statutory methodology.

For example, for anesthesia services furnished by a medically directed qualified anesthetist in 1994, the medically directed allowance is 60 percent of the allowance that would be recognized for the anesthesia service if the physician personally performed the service without an assistant, i.e., alone. For subsequent years, the medically directed allowance is the following percent of the personally performed allowance.

Services furnished in 1995	57.5 percent
Services furnished in 1996	55.0 percent
Services furnished in 1997	52.5 percent
Services furnished in 1998 and after	50.0 percent

150 - Clinical Social Worker (CSW) Services

(Rev. 1, 10-01-03)

B3-2152, B3-17000

See Medicare Benefit Policy Manual, Chapter 15, for coverage requirements.

Assignment of benefits is required.

Payment is at 75 percent of the physician fee schedule.

CSWs are identified on the provider file by specialty code 80 and provider type 56.

Medicare applies the outpatient mental health limitation to all covered therapeutic services furnished by qualified CSWs. Refer to §210, below, for a discussion of the outpatient mental health limitation. The modifier “AJ” must be applied on CSN services.

160 - Independent Psychologist Services

(Rev. 1, 10-01-03)

B3-2150, B3-2070.2

See the Medicare Benefit Policy Manual, Chapter 15, for coverage requirements.

There are a number of types of psychologists. Educational psychologists engage in identifying and treating education-related issues. In contrast, counseling psychologists provide services that include a broader realm including phobias, familial issues, etc. Psychometrists are psychologists who have been trained to administer and interpret tests. However, clinical psychologists are defined as a provider of diagnostic and therapeutic services. Because of the differences in services provided, services provided by psychologists who do not provide clinical services are subject to different billing guidelines. One service often provided by nonclinical psychologist is diagnostic testing.

NOTE: Diagnostic psychological testing services performed by persons who meet these requirements are covered as other diagnostic tests. When, however, the psychologist is not practicing independently, but is on the staff of an institution, agency, or clinic, that entity bills for the diagnostic services.

Expenses for such testing are not subject to the payment limitation on treatment for mental, psychoneurotic, and personality disorders. Independent psychologists are not required by law to accept assignment when performing psychological tests. However, regardless of whether the psychologist accepts assignment, he or she must report on the claim form the name and address of the physician who ordered the test.

160.1 - Payment

(Rev. 1, 10-01-03)

Diagnostic testing services are not subject to the outpatient mental health limitation. Refer to §210, below, for a discussion of the outpatient mental health limitation.

The diagnostic testing services performed by a psychologist (who is not a clinical psychologist) practicing independently of an institution, agency, or physician's office are covered as other diagnostic tests if a physician orders such testing. Medicare covers this type of testing as an outpatient service if furnished by any psychologist who is licensed or certified to practice psychology in the State or jurisdiction where he or she is furnishing services or, if the jurisdiction does not issue licenses, if provided by any practicing psychologist. (It is CMS' understanding that all States, the District of Columbia, and Puerto Rico license psychologists, but that some trust territories do not. Examples of psychologists, other than clinical psychologists, whose services are covered under this provision include, but are not limited to, educational psychologists and counseling psychologists.)

To determine whether the diagnostic psychological testing services of a particular independent psychologist are covered under Part B in States which have statutory licensure or certification, carriers must secure from the appropriate State agency a current listing of psychologists holding the required credentials. In States or territories which lack statutory licensing and certification, carriers must check individual qualifications as claims are submitted. Possible reference sources are the national directory of membership of the American Psychological Association, which provides data about the educational background of individuals and indicates which members are board-certified, and records and directories of the State or territorial psychological association. If qualification is dependent on a doctoral degree from a currently accredited program, carriers must verify the date of accreditation of the school involved, since such accreditation is not retroactive. If the reference sources listed above do not provide enough information (e.g., the psychologist is not a member of the association), carriers must contact the psychologist personally for the required information. Carriers may wish to maintain a continuing list of psychologists whose qualifications have been verified.

Medicare excludes expenses for diagnostic testing from the payment limitation on treatment for mental/psychoneurotic/personality disorders.

Carriers must identify the independent psychologist's choice whether or not to accept assignment when performing psychological tests.

Carriers must accept an independent psychologist claim only if the psychologist reports the name/UPIN of the physician who ordered a test.

Carriers pay nonparticipating independent psychologists at 95 percent of the physician fee schedule allowed amount. Carriers pay participating independent psychologists at 100 percent of the physician fee schedule allowed amount.

Independent psychologists are identified on the provider file by specialty code 62 and provider type 35.

170 - Clinical Psychologist Services

(Rev. 1, 10-01-03)

B3-2150

See Medicare Benefit Policy Manual, Chapter 15, for general coverage requirements.

Direct payment may be made under Part B for professional services. However, services furnished incident to the professional services of CPs to hospital patients remain bundled. Therefore, payment must continue to be made to the hospital (by the FI) for such “incident to” services.

170.1 - Payment

(Rev. 1, 10-01-03)

B3-2150, B3-17001.1

All covered therapeutic services furnished by qualified CPs are subject to the outpatient mental health services limitation (i.e., only 62 1/2 percent of expenses for these services are considered incurred expenses for Medicare purposes). The limitation does not apply to diagnostic services. Refer to §210 below for a discussion of the outpatient mental health limitation.

Payment for the services of CPs is made on the basis of a fee schedule or the actual charge, whichever is less, and only on the basis of assignment.

CPs are identified by specialty code 68 and provider type 27. Modifier “AH” is required on CP services.

180 - Care Plan Oversight Services

(Rev. 1, 10-01-03)

B-00-65, B3-5513

The Medicare Benefit Policy Manual, Chapter 15, contains requirements for coverage.

Care plan oversight (CPO) is the physician supervision of patients under the care of home health agencies or hospices that require complex or multidisciplinary care modalities involving:

- Regular physician development and/or revision of care plans;

- Review of subsequent reports of patient status;
- Review of related laboratory and other studies;
- Communication with other health professionals not employed in the same practice who are involved in the patient's care;
- Integration of new information into the medical treatment plan, and/or
- Adjustment of medical therapy.

Services not countable toward the 30 minutes threshold that must be provided in order to bill for CPO include, but are not limited to:

- Time associated with discussions with the patient, his or her family or friends to adjust medication or treatment;
- Time spent by staff getting or filing charts;
- Travel time; and/or
- Physician's time spent telephoning prescriptions in to the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.

Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the home health agency or hospice during the month for which CPO services were billed.

180.1 - Care Plan Oversight Billing Requirements

(Rev. 1, 10-01-03)

A - Codes for Which Separate Payment May Be Made

Effective January 1, 1995, separate payment may be made for code 99375 if the requirements specified in the Medicare Benefits Policy Manual, Chapter 15 are met. No separate payment may be made for HCPCS code 99376. The services described by HCPCS code 99376 are covered, but the payment is included in the payment amount for CPT 99375.

Effective 2001, two new HCPCS codes were established for care plan oversight, codes G0179 and G0182, due to revisions CPT made to existing CPT codes 99375 and 99378. The definitional revisions to CPT codes 99375 and 99378 were inconsistent with Medicare policy as the new CPT definitions defined the code to include, as physician work, communication with nonprofessionals, which current Medicare policy does not recognize for purposes of CPO.

Communication with nonprofessionals is part of the pre/post service work of other evaluation and management services and is not attributable to CPO. Therefore, for 2001, all RVUs and indicators were crosswalked from former CPT codes 99375 and 99378 to new HCPCS codes G0181 and G0182. Effective 2001, CPT codes 99375 and 99378 are noncovered services on the database.

Under the provisions of the Balanced Budget Act of 1997, nurse practitioners, physician assistants, and clinical nurse specialists, practicing within the scope of State law, may bill for care plan oversight. These nonphysician practitioners must be providing ongoing care for the beneficiary through evaluation and management services (but not if they are involved only in the delivery of the Medicare covered home health or hospice service).

Providers billing for CPO must submit the claim with no other services billed on that claim and may bill only after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months and should be submitted (and paid) only for one unit of service.

Physicians may bill and be paid separately only if all the criteria in the Medicare Benefit Policy Manual, Chapter 15 are met.

B - Physician Certification and Recertification of Home Health Plans of Care

Effective 2001, two new HCPCS codes for the certification (HCPCS code G0180) and recertification (HCPCS code G0179) and development of plans of care for Medicare-covered home health services were created. The use of these two new HCPCS codes are available only to physicians who are permitted to certify that home health services are required by a patient in accordance with to §1814(a)(2)(C) and §1835(a)(2)(A) of the Act. The home health agency certification code (HCPCS code G0180) can be billed only when the patient has not received Medicare-covered home health services for at least 60 days. The home health agency recertification code (HCPCS code G0179) is used after a patient has received services for at least 60 days (or one certification period) when the physician signs the certification after the initial certification period. HCPCS code G0179 will be reported only once every 60 days, except in the rare situation when the patient starts a new episode before 60 days elapses and requires a new plan of care to start a new episode.

C - Provider Number of Home Health Agency (HHA) or Hospice

For claims for CPO submitted on or after January 1, 1997, physicians must enter on the Medicare claim form the 6-character Medicare provider number of the HHA or hospice providing Medicare covered services to the beneficiary for the period during which CPO services were furnished and for which the physician signed the plan of care. Physicians are responsible for obtaining the HHA or hospice Medicare provider numbers. Additionally, physicians should provide their UPIN to the HHA or hospice furnishing services to their patient.

190 - Medicare Payment for Telehealth Services

(Rev. 1, 10-01-03)

A3-3497, A3-3660.2, B3-4159, B3-15516

190.1 - Background

(Rev. 1, 10-01-03)

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended §1834 of the Act to provide for an expansion of Medicare payment for telehealth services.

Effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system. Eligible geographic areas include rural health professional shortage areas and counties not classified as a metropolitan statistical area (MSA). Additionally, Federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous “store and forward” technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. BIPA does not require that a practitioner present the patient for interactive telehealth services.

With regard to payment amount, BIPA specified that payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telemedicine encounter) is equal to what would have been paid without the use of telemedicine. Distant site practitioners include only a physician as described in §1861(r) of the Act and a medical practitioner as described in §1842(b)(18)(C) of the Act. BIPA also expanded payment under Medicare to include a \$20 originating site facility fee (location of beneficiary).

Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services and the implementing regulation prohibited the use of an asynchronous, ‘store and forward’ telecommunications system. BBA 1997 also required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

BIPA required that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001.

Time limit for teleconsultation provision.

The teleconsultation provision as authorized by §4206 (a) and (b) of the BBA of 1997 and implemented in 42 CFR 410.78 and 414.65 applies only to teleconsultations provided on or after January 1, 1999, and before October 1, 2001.

190.2 - Eligibility Criteria

(Rev. 1, 10-01-03)

1. Beneficiaries eligible for telehealth services

Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in either a rural health professional shortage area (HPSA) as defined by §332(a)(1) (A) of the Public Health Services Act or in a county outside of a MSA as defined by §1886(d)(2)(D) of the Act.

2. Exception to rural HPSA and non MSA geographic requirements

Entities participating in a Federal telemedicine demonstration project that were approved by or were receiving funding from the Secretary of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. Such entities are not required to be in a rural HPSA or non-MSA.

3. Originating site defined

The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites authorized by law are listed below:

- The office of a physician or practitioner;
- A hospital (inpatient or outpatient);
- A critical access hospital (CAH);
- A rural health clinic (RHC); and
- A federally qualified health center (FQHC);

For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

190.3 - List of Medicare Telehealth Services

(Rev. 1, 10-01-03)

The use of a telecommunications system may substitute for a face-to-face, “hands on” encounter for consultation, office visits, individual psychotherapy, and pharmacologic management. These services and corresponding current procedure terminology (CPT) codes are listed below.

- Consultations (CPT codes 99241 - 99275);
- Office or other outpatient visits (CPT codes 99201 - 99215);
- Individual psychotherapy (CPT codes 90804 - 90809);
- Pharmacologic management (CPT code 90862); and
- Psychiatric diagnostic interview examination (CPT code 90801) – Effective March 1, 2003.

190.4 - Conditions of Payment

(Rev. 1, 10-01-03)

1. Technology

For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

2. Exception to the interactive telecommunications requirement

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, Medicare payment is permitted for telemedicine when asynchronous “store and forward technology” in single or multimedia formats is used as a substitute for an interactive telecommunications system. The originating site and distant site practitioner must be included within the definition of the demonstration program.

3. “Store and forward” defined

For purposes of this instruction, “store and forward” means the asynchronous transmission of medical information to be reviewed at a later time by physician or practitioner at the distant site. A patient’s medical information may include, but not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

NOTE: Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis and or treatment plan. Dermatological photographs, e.g., a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

4. Telepresenters

A medical professional is not required to present the beneficiary to physician or practitioner at the distant site unless medically necessary. The decision of medical necessity will be made by the physician or practitioner located at the distant site.

190.5 - Payment Methodology for Physician/Practitioner at the Distant Site

(Rev. 1, 10-01-03)

1. Distant site defined

The term "distant site" means the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunications system.

2. Payment amount (professional fee)

The payment amount for the professional service provided via a telecommunications system by the physician or practitioner at the distant site is equal to the current fee schedule amount for the service provided. Payment for an office visit, consultation, individual psychotherapy or pharmacologic management via a telecommunications system should be made at the same amount as when these services are furnished without the use of a telecommunications system. For Medicare payment to occur, the service must be within a practitioner's scope of practice under State law. The beneficiary is responsible for any unmet deductible amount and applicable coinsurance.

3. Medicare practitioners who may receive payment at the distant site (i.e., at a site other than where beneficiary is)

As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under State law. When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, and pharmacologic management) then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

4. Medicare practitioners who may bill for covered telehealth services are listed below (subject to State law)

- Physician.
- Nurse practitioner.
- Physician assistant.
- Nurse-midwife.
- Clinical nurse specialist.
- Clinical psychologist.*
- Clinical social worker.*

*Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

190.6 - Originating Site Facility Fee Payment Methodology

(Rev. 1, 10-01-03)

1. Originating site defined

The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

2. Facility fee for originating site (See B, above, for definition of originating site.)

The originating site facility fee is a Part B payment. The contractor pays it outside of the current fee schedule or other payment methodologies (e.g., FIs make payment in addition to the DRG, or OPSS). For consultation, office or other outpatient visit, psychotherapy and pharmacologic management services delivered via a telecommunications system furnished from October 1, 2001, through December 31, 2002, the originating site fee is the lesser of \$20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the Medicare Economic Index (MEI) will update the facility site fee for the originating site annually. This fee is subject to post payment verification

3. Payment amount:

- For telehealth services furnished from October 1, 2001, through December 31, 2002, the payment amount to the originating site is the lesser of the actual charge or the originating site facility fee of \$20. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance. The originating site facility fee payment methodology for each type of facility is clarified below.
- Hospital outpatient department. When the originating site is a hospital outpatient department, payment for the originating site facility fee must be made as described above and not under the outpatient prospective payment system. Payment is not based on current fee schedules or other payment methodologies.
- Hospital inpatient. For hospital inpatients, payment for the originating site facility fee must be made outside the Diagnostic related group (DRG) payment, since this is a Part B benefit, similar to other services paid separately from the DRG payment, (e.g., hemophilia blood clotting factor).
- Critical access hospitals. When the originating site is a critical access hospital, make payment as described above, separately from the cost-based reimbursement methodology.
- Federally qualified health centers (FQHCs) and rural health clinics (RHCs). The originating site facility fee for telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.
- Physicians' and practitioners' offices. When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of the actual charge or \$20 regardless of geographic location. The carrier shall not apply the geographic practice cost index (GPCI) to the originating site facility fee. This fee is statutorily set and is not subject to the geographic payment adjustments authorized under the physician fee schedule.

To receive the originating facility site fee, the provider submits claims with HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural or non-MSA county.

This benefit may be billed on bill types 13X, 71X, 73X, and 85X. The originating site can be located in a number of revenue centers within a facility, such as an emergency room (0450), operating room (0360), or clinic (0510). Report this service under the revenue center where the service was performed and include HCPCS code "Q3014, telehealth originating site facility fee."

Hospitals and critical access hospitals bill their intermediary for the originating site facility fee. Telehealth bills originating in inpatient hospitals must be submitted on an 13X (outpatient) TOB using the date of discharge as the line item date of service. Independent and provider-based RHCs and FQHCs bill the appropriate intermediary using the RHC or FQHC bill type and billing number. HCPCS code Q3014 is the only non-RHC/FQHC service that is billed using the clinic/center bill type and provider number. For all other non-RHC/FQHC service, provider based RHCs and FQHCs must bill using the provider's bill type and billing number. Independent RHCs and FQHCs must bill the carrier for all other non-RHC/FQHC services. If an RHC/FQHC visit occurs on the same day as a telehealth service, the RHC/FQHC serving as an originating site must bill for HCPCS code Q3014 telehealth originating site facility fee on a separate revenue line from the RHC/FQHC visit.

The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners

(Rev. 1, 10-01-03)

Claims for professional consultations, office visits, individual psychotherapy, and pharmacologic management provided via a telecommunications system are submitted to the carrier that processes claims for the performing physician/practitioner's service area. Physicians/practitioners submit the appropriate CPT procedure code for covered professional telehealth services along with the "GT" modifier ("via interactive audio and video telecommunications system"). By coding and billing the "GT" modifier with a covered telehealth procedure code, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished.

To claim the facility payment, physicians/practitioners will bill HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services." For carrier-processed claims, the "office" place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014 and it is not priced off of the MPFS Database file. Deductible and coinsurance rules apply to Q3014. By submitting HCPCS code "Q3014," the biller certifies that the originating site is located in either a rural HPSA or a non-MSA county.

Physicians and practitioners at the distant site bill their local Medicare carrier for covered telehealth services, for example, "99245 GT." Physicians' and practitioners' offices serving as a telehealth originating site bill their local Medicare carrier for the originating site facility fee.

190.6.2 - Exception for Store and Forward (Noninteractive) Telehealth

(Rev. 1, 10-01-03)

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, store and forward technologies may be used as a substitute for an interactive telecommunications system. Covered store and forward telehealth services are billed with the “GQ” modifier, “via asynchronous telecommunications system.” By using the “GQ” modifier, the distant site physician/practitioner certifies that the asynchronous medical file was collected and transmitted to them at their distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

190.7 - Carrier Editing of Telehealth Claims

(Rev. 1, 10-01-03)

Effective October 1, 2001, covered telehealth services include CPT codes 99241 – 99275, 99201 – 99215, 90801 (effective March 1, 2003), 90804 - 90809, and 90862. When furnished as telehealth services these codes are billed with either the “GT” or “GQ” modifier.

The carrier shall approve covered telehealth services if the physician or practitioner is licensed under State law to provide the service. Carriers must familiarize themselves with licensure provisions of States for which they process claims and disallow telehealth services furnished by physicians or practitioners who are not authorized to furnish the applicable telehealth service under State law. For example, if a nurse practitioner is not licensed to provide individual psychotherapy under State law, he or she would not be permitted to receive payment for individual psychotherapy under Medicare. The carrier shall install edits to ensure that only properly licensed physicians and practitioners are paid for covered telehealth services.

If a carrier receives claims for professional telehealth services coded with the “GQ” modifier (representing “via asynchronous telecommunications system”), it shall approve/pay for these services only if the physician or practitioner is affiliated with a Federal telemedicine demonstration conducted in Alaska or Hawaii. The carrier may require the physician or practitioner at the distant site to document his or her participation in a Federal telemedicine demonstration program conducted in Alaska or Hawaii prior to paying for telehealth services provided via asynchronous, store and forward technologies.

If a carrier denies telehealth services because the physician or practitioner may not bill for them, the carrier uses MSN message 21.18: “This item or service is not covered when performed or ordered by this practitioner.” The carrier uses remittance advice message 5.2 when denying the claim based upon MSN message 21.18.

If a service is billed with one of the telehealth modifiers and the procedure code is not designated as a covered telehealth service, the carrier denies the service using MSN message 9.4: “This item or service was denied because information required to make

payment was incorrect.” The remittance advice message depends on what is incorrect, e.g., B18 if procedure code or modifier is incorrect, 125 for submission billing errors, 4-12 for difference inconsistencies. The carrier uses B18 as the explanation for the denial of the claim.

200 - Allergy Testing and Immunotherapy

(Rev. 1, 10-01-03)

B3-15050

A - Allergy Testing

The MPFSDB fee amounts for allergy testing services billed under codes 95004-95078 are established for single tests. Therefore, the number of tests must be shown on the claim.

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 - CPT codes 95120 through 95134 are not valid for Medicare. 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 - Separate coding for injection only codes (i.e., codes 95115 and 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170) must be used.

If both services are provided both codes are billed.

This includes allergists who provide both services through the use of treatment boards.

- 3 - If a physician bills both an injection code plus either codes 95165 or 95144, carriers 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, carriers 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, carriers 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, carriers are not to pay more because the number of doses provided in the original vial(s) increased. In the second case, carriers are not to seek recoupment (if carriers have already made payment) because the number of doses is less than originally planned. This is the case for both venom and nonvenom 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 vespoid 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 vespoid 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, the carrier 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 five 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 and Catch-Up Billing - Code 95165 represents multiple dose vials of nonvenom antigens. As in the case of venoms, some nonvenom antigens can not 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. A dose of code 95165 is the total amount of antigen to be administered to a patient during one treatment session, whether mixed or in separate vials. Therefore, if a physician mixes a 10 cc vial of mold and a separate 10 cc vial of pollen for a patient, and at each of 10 visits the plan is that the patient is to receive an injection from each vial, the physician has provided the patient with 10 doses of code 95165. Those 20 ccs together constitute 10 doses. Similarly, if a physician mixes for a patient 2 - 10 cc vials of mixed antigen and plans to administer those vials over 10 visits, this too would constitute 10 doses of code 95165. In cases where nonvenom antigens cannot be mixed and dose adjustments lead to one vial lasting longer than the other, carriers may pay physicians to prepare doses of the depleted antigen only up to the amount needed for administration with the remaining antigen. Although technically the catch-up antigen does not comprise doses of code 95165 for the particular patient (because it is not the total antigen to be administered to that patient during one visit), the physician may bill and be paid for the “catch-up” antigen as doses of code 95165. For example, if there is mold antigen left to be administered over three visits, when the physician prepares pollen antigen to be administered over those same three visits, the physician may bill for three doses of pollen. Further antigen preparation and billing must return to the practice of 1 dose representing the total of what will be administered to the patient during one encounter.

C - Allergy Shots and Visit Services on Same Day

Effective for services provided on or after January 1, 1995, visits may not be paid with allergy injection services 95115 through 95199 unless the visit represents another separately identifiable service. Modifier code -25 is used with the visit code to report the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

Prior to January 1, 1995, in some cases both visits and allergy injections were paid.

D - Reasonable Supply of Antigens

See the Medicare Benefit Policy Manual regarding the coverage of antigens, including what constitutes a reasonable supply of antigens.

210 - Outpatient Mental Health Limitation

(Rev. 1, 10-01-03)

B3-2470

Regardless of the actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare allowed amount for those services. This limitation is called the outpatient mental health treatment limitation. Expenses for diagnostic services (e.g., psychiatric testing and evaluation to diagnose the patient's illness) are not subject to this limitation. This limitation applies only to therapeutic services and to services performed to evaluate the progress of a course of treatment for a diagnosed condition.

210.1 - Application of Limitation

(Rev. 1, 10-01-03)

B3-2472 - 2472.5

A - Status of Patient

The limitation is applicable to expenses incurred in connection with the treatment of an individual who is not an inpatient of a hospital. Thus, the limitation applies to mental health services furnished to a person in a physician's office, in the patient's home, in a skilled nursing facility, as an outpatient, and so forth. The term "hospital" in this context means an institution, which is primarily engaged in providing to inpatients, by or under the supervision of physician(s):

- Diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons;

- Rehabilitation services for injured, disabled, or sick persons; or
- Psychiatric services for the diagnosis and treatment of mentally ill patients.

B - Disorders Subject to Limitation

The term “mental, psychoneurotic, and personality disorders” is defined as the specific psychiatric conditions described in the American Psychiatric Association’s (APA) “Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM-III-R).”

When the treatment services rendered are both for a psychiatric condition as defined in the DSM-III-R and one or more nonpsychiatric conditions, separate the expenses for the psychiatric aspects of treatment from the expenses for the nonpsychiatric aspects of treatment. However, in any case in which the psychiatric treatment component is not readily distinguishable from the nonpsychiatric treatment component, all of the expenses are allocated to whichever component constitutes the primary diagnosis.

1. **Diagnosis Clearly Meets Definition** - If the primary diagnosis reported for a particular service is the same as or equivalent to a condition described in the APA’s DSM-III-R, the expense for the service is subject to the limitation except as described in subsection D.
2. **Diagnosis Does Not Clearly Meet Definition** - When it is not clear whether the primary diagnosis reported meets the definition of mental, psychoneurotic, and personality disorders, it may be necessary to contact the practitioner to clarify the diagnosis. In deciding whether contact is necessary in a given case, give consideration to such factors as the type of services rendered, the diagnosis, and the individual’s previous utilization history.

C - Services Subject to Limitation

Carriers apply the limitation to claims for professional services that represent mental health treatment furnished to individuals who are not hospital inpatients by physicians, clinical psychologists, clinical social workers, and other allied health professionals. Items and supplies furnished by physicians or other mental health practitioners in connection with treatment are also subject to the limitation. (The limitation also applies to CORF claims processed by intermediaries.)

Carriers apply the limitation only to treatment services. It does not apply to diagnostic services as described in subsection D. Testing services performed to evaluate a patient’s progress during treatment are considered part of treatment and are subject to the limitation.

D - Services Not Subject to Limitation

1. **Diagnosis of Alzheimer's Disease or Related Disorder** - When the primary diagnosis reported for a particular service is Alzheimer's Disease (coded 331.0 in the "International Classification of Diseases, 9th Revision") or Alzheimer's or other disorders coded 290.XX in the APA's DSM-III-R, carriers look to the nature of the service that has been rendered in determining whether it is subject to the limitation. Typically, treatment provided to a patient with a diagnosis of Alzheimer's Disease or a related disorder represents medical management of the patient's condition (rather than psychiatric treatment) and is not subject to the limitation. However, when the primary treatment rendered to a patient with such a diagnosis is psychotherapy, it is subject to the limitation.
2. **Brief Office Visits for Monitoring or Changing Drug Prescriptions** - Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic and personality disorders are not subject to the limitation. These visits are reported using HCPCS code M0064 (brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders). Claims where the diagnosis reported is a mental, psychoneurotic, or personality disorder (other than a diagnosis specified in subsection A) are subject to the limitation except for the procedure identified by HCPCS code M0064.
3. **Diagnostic Services** - Carriers do not apply the limitation to tests and evaluations performed to establish or confirm the patient's diagnosis. Diagnostic services include psychiatric or psychological tests and interpretations, diagnostic consultations, and initial evaluations.

An initial visit to a practitioner for professional services often combines diagnostic evaluation and the start of therapy. Such a visit is neither solely diagnostic nor solely therapeutic. Therefore, carriers deem the initial visit to be diagnostic so that the limitation does not apply. Separating diagnostic and therapeutic components of a visit is not administratively feasible, unless the practitioner already has separately identified them on the bill. Determining the entire visit to be therapeutic is not justifiable since some diagnostic work must be done before even a tentative diagnosis can be made and certainly before therapy can be instituted. Moreover, the patient should not be disadvantaged because therapeutic as well as diagnostic services were provided in the initial visit. In the rare cases where a practitioner's diagnostic services take more than one visit, carriers do not apply the limitation to the additional visits. However, it is expected such cases are few. Therefore, when a practitioner bills for more than one visit for professional diagnostic services, carriers request documentation to justify the reason for more than one diagnostic visit.

4. Partial Hospitalization Services Not Directly Provided by Physician - The limitation does not apply to partial hospitalization services that are not directly provided by a physician. These services are billed by hospitals and community mental health centers (CMHCs) to intermediaries.

E - Computation of Limitation

Carriers determine the Medicare allowed payment amount for services subject to the limitation. They:

- Multiply this amount by 0.625;
- Subtract any unsatisfied deductible; and,
- Multiply the remainder by 0.8 to obtain the amount of Medicare payment.

The beneficiary is responsible for the difference between the amount paid by Medicare and the full allowed amount.

EXAMPLE A

A beneficiary is referred to a Medicare participating psychiatrist who performs a diagnostic evaluation that costs \$350. Those services are not subject to the limitation, and they satisfy the deductible. The psychiatrist then conducts 10 weekly therapy sessions for which he/she charges \$125 each. The Medicare allowed amount is \$90 each, for a total of \$900.

Apply the limitation by multiplying 0.625 times \$900, which equals \$562.50.

Apply regular 20 percent coinsurance by multiplying 0.8 times \$562.50, which equals \$450 (the amount of Medicare payment).

The beneficiary is responsible for \$450 (the difference between Medicare payment and the allowed amount).

EXAMPLE B

A beneficiary was an inpatient of a psychiatric hospital and was discharged on January 1, 1992. During his/her inpatient stay he/she was diagnosed and therapy was begun under a treatment team that included a clinical psychologist. He/she received post-discharge therapy from the psychologist for 12 sessions, at which point the psychologist administered testing that showed the patient had recovered sufficiently to warrant termination of therapy. The allowed amount for the therapy sessions was \$80 each, and the amount for the testing was \$125, for a total of \$1085. All services in 1992 were subject to the limitation, since the diagnosis had been completed in the hospital and the subsequent testing was a part of therapy.

Apply the limitation by multiplying 0.625 times \$1085, which gives \$678.13.

Since the deductible must be met for 1992, subtract \$100 from \$678.13, for a remainder of \$578.13.

Determine Medicare payment by multiplying the remainder by 0.8, which equals \$462.50.

The beneficiary is responsible for \$622.50.

220 – Chiropractic Services

(Rev. 137, 04-09-04)

B3-4118

A - Verification of Chiropractor's Qualifications

Establish a reference file of chiropractors eligible for payment as physicians under the criteria in Pub. 100-02, Benefits Policy Manual, Chapter 15, Sections 30.5 & 240A. Pay only chiropractors on file. Information needed to establish such files is furnished by the RO.

The RO is notified by the appropriate State agency which chiropractors are licensed and whether each meets the national uniform standards.

B - Durable Medical Equipment Regional Carriers Processing Claims When a Chiropractor is the Supplier

Effective July 1, 1999, except for restrictions to chiropractor services as stipulated in §§1861(s)(2)(A) of the Social Security Act, chiropractors (specialty 35) can bill for durable medical equipment, prosthetics, orthotics and supplies if, as the supplier, they have a valid supplier number assigned by the National Supplier Clearinghouse. In order to process claims, the Common Working File has been changed to allow specialty 35 to bill for services furnished as a supplier.

C – Documentation

The following information must be recorded by the chiropractor and kept on file. The date of the initial treatment or date of exacerbation of the existing condition must be entered in Item 14 of Form CMS-1500. This serves as affirmation by the chiropractor that all documentation required as listed below and in Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.2 is being maintained on file by the chiropractor.

1. Specification of the precise spinal location and level of subluxation (see Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.4) giving rise to the diagnosis and symptoms.

2. Effective for claims with dates of service on and after January 1, 2000, the x-ray is no longer required. However, the x-ray may still be used to demonstrate subluxation for claims processing purposes. Effective for claims with dates of service on or after October 1, 2000, when the x-ray is used to demonstrate subluxation, the date of the x-ray must be entered in Item 19 of Form CMS-1500 and the date must be within the

parameters specified in Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.2.

For claims with dates of service prior to January 1, 2000, and for claims with dates of service on or after October 1, 2000, for which an x-ray is still used to show subluxation, the following instructions on documentation apply:

An x-ray film (including the date of the film) is available for your review demonstrating the existence of a subluxation at the specified level of the spine. If the beneficiary refuses to have the x-ray, the chiropractor must submit one of the appropriate HCPCS codes for chiropractic manipulation in addition to modifier GX (service not covered by Medicare), and the claim will be denied as a technical denial.

The following Medicare Summary Notice (MSN) message must be generated:

MSN 3.1 - "This service is covered only when recent x-rays support the need for the service."

The following remittance advice (RA) message must be generated:

Claims adjustment reason code 96, - "noncovered charge (s)," and

Line level remark code M111, " We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken."

NOTE: The refusal of the beneficiary to have an x-ray taken will no longer need to be coded for claims with dates of service on or after January 1, 2000.

D - Claims Processing

Edits and suggested MSN and RA messages.

1. Do not pay for manual manipulation of the spine in treating conditions other than those indicated in Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.3 and deny claims for treatment of any condition not reasonably related to a subluxation involving vertebrae at the spinal level specified. Use the MSN 15.4, "The information provided does not support the need for this service or item." For the RA, use the Claims Adjustment Reason Code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."

2. Edit to verify that the claim has the primary diagnosis of subluxation. Use the MSN 15.4, "The information provided does not support the need for this service or item." For the RA, use the Claims Adjustment Reason Code B22, "This payment is adjusted based on the diagnosis."

3. Edit to verify that the date of the initial visit or the date of exacerbation of the existing condition is entered in Item 14 of Form CMS-1500. Use the MSN 9.2, "This item or service was denied because information required to make payment was missing." For the RA, use the Claims Adjustment Reason Code 16, "Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate."

E - X-ray Review

Effective for claims with dates of service on and after January 1, 2000, the x-ray is no longer required. However, effective for claims with dates of service on or after October

1, 2000, should the chiropractor choose to use the x-ray to show subluxation, the x-ray review process is still required as outlined below minus the requirement in the last sentence of number 2. For claims with dates of service prior to January 1, 2000, all aspects of the following instructions still apply.

1. Carriers should conduct post-payment reviews of x-rays on a sample basis. Prepayment review should be undertaken in all questionable cases.

2. It is the responsibility of the treating chiropractor to make the documenting x-ray(s) available to the carrier's review staff. If x-rays are not made available, or suggest a pattern in failing to demonstrate subluxation for any reason, including unacceptable technical quality, the carrier should conduct prepayment review of x-rays in 100 percent of the subsequent claims for treatments by the practitioner involved until satisfied that the deficiency will no longer occur. Where there is no x-ray documentation of subluxation on prepayment review, the claims, of course, should be denied. (The last sentence of this paragraph only refers to claims with dates of service prior to January 1, 2000.)

3. The x-ray film(s) must have been taken at a time reasonably proximate to the initiation of the course of treatment and must demonstrate a subluxation at the level of the spine specified by the treating chiropractor on the claim. (See Pub. 100-02, Benefits Policy Manual, Chapter 15, Section 240.1.2.)

4. An x-ray obtained by the chiropractor for his own diagnostic purposes before commencing treatment should suffice for claims documentation purposes. However, when subluxation was for treatment purposes diagnosed by some other means and x-rays are taken to satisfy Medicare's documentation requirement, carriers should ask chiropractors to hone in on the site of the subluxation in producing x-rays. Such a practice would not only minimize the exposure of the patient but also should result in a film more clearly portraying the subluxation.

5. An x-ray will be considered of acceptable technical quality if any individual trained in the reading of x-rays could recognize a subluxation if present.

6. When claims have been denied because the x-ray(s) initially offered failed to document the existence of a subluxation requiring treatment, no review of these decisions should be undertaken on the basis of x-ray(s) subsequently taken. Permitting such reviews could be an inducement to excessive exposure of patients to radiation in cases where the decision to treat was made despite x-rays that did not show a subluxation.