Medicare
Carriers Manual
Part 3 - Claims Process

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

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents – Chapter XV	15-1 – 15-2 (2 pp.)	15-1 – 15-2 (2 pp.)
15002 – 15006 (Cont.)	15-3 – 15-4.1 (3 pp.)	15-3 – 15-4.1 (3 pp.)
15200 – 15501 (Cont.)	15-71 – 15-74.1 (5 pp.)	15-71 – 15-74.1 (5 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2002*
IMPLEMENTATION DATE: May 17, 2002

Section 15002, Physicians' Services Paid Under Fee Schedule, is revised to clarify the payment policy for bad debts.

Section 15302, Group Therapy Services (Code 97150), is added to clarify payment policy for group therapy services.

CLARIFICATION/MANUALIZATION--*EFFECTIVE DATE: Not Applicable*
IMPLEMENTATION DATE: Not Applicable

Section 15304, Therapy Students, manualizes PM AB-01-56, "Questions and Answers Regarding Payment for the Services of Therapy Students Under Part B of Medicare."

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

These instructions should be implemented within your current operating budget.

CHAPTER XV
FEE SCHEDULE FOR PHYSICIANS' SERVICES

15000. SCHEDULE FOR PHYSICIANS' SERVICES

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

15002. PHYSICIANS' SERVICES PAID UNDER FEE SCHEDULE

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

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

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

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

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

- Radiology services; and

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

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

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

There is no payment for bad debts (unrecovered costs attributable to uncollectible deductible and coinsurance arising from covered services to beneficiaries considered in calculating payment to providers reimbursed on the basis of reasonable cost) with respect to services paid under the Medicare physician fee schedule. Under a fee schedule, payment is not based on incurred costs; rather payment is made based on a schedule for the specific service furnished. Whether a fee schedule has its basis in charges or is resource-based, the payment is not related to a specific

provider's cost outlay for a service and does not embody the concept of unrecovered cost.

Bad debts are allowable only to an entity to whom payment is made on the basis of reasonable cost.

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

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

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

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

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

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

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

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

- An independent laboratory doing anatomic pathology services.

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

15006. METHOD FOR COMPUTING FEE SCHEDULE AMOUNT

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

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

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

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

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

- A GPCI for physician work (GPCIw),

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

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

2001	$38.2581	2000	$36.6137	1999	$34.7315	1998	$36.6873
1997	$40.9603(S) $33.8454(NS) $35.7671(PC)	1996	$40.7986(S) $34.6293(NS) $35.4173(PC)	1995	$39.447(S) $34.616(NS) $36.382(PC)	1994	$35.158(S) $32.905(NS) $33.718(PC)
1993	$31.962(S) $31.249(NS)	1992	$31.001				

S= Surgical NS= Nonsurgical PC= Primary Care

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

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

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

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

2002 - 100 percent of the resource-based RVUs.

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

Example of Computation of Fee Schedule Amount

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

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

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

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

15070. INTEGUMENTARY SYSTEM (CODES 10040 - 19499)

Bundling of Repair Codes into Excision of Benign Lesion Codes.--Payment for the excision of benign or malignant lesions of skin includes payment for simple repairs. Separate payment for simple repairs (CPT codes 12001 through 12018) will not be made when reported with the CPT codes for the excision of benign lesions (11400 through 11446) or the excision of malignant lesions (11600 through 11646).

Payment for the excision of benign lesions with a lesion diameter of 0.5 cm or less (CPT 11400, 11420, 11440) includes payment for simple, intermediate or complex repairs. In other words, separate payment for simple, intermediate or complex repairs (CPT 12001 through 12018) will not be made when reported with CPT codes 11400, 11420, and 11440.

Use existing definitions for simple, intermediate, and complex repairs listed in the American Medical Association's Physicians' Current Procedural Terminology, CPT. Payment for the excision of a benign lesion with a lesion diameter greater than 0.5 cm or the excision of a malignant lesion of any size does not include payment for intermediate or complex repairs. Separate payment for medically necessary intermediate repairs (CPT 12031 through 12057) or medically necessary complex repairs
(CPT codes 13100 through 13152) may be made when reported with CPT codes 11401 through 11406, 11421 through 11426, 11441 through 11446, and 11600 through 11646.

15100. DIGESTIVE SYSTEM (CODES 40000-49999)

A. Upper Gastrointestinal Endoscopy Including Endoscopic Ultrasound (EUS) (Code 43259).--If the person doing 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 nonintended 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.

15200. URINARY AND MALE GENITAL SYSTEMS (CODES 50010-55899)

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.

15300. OTOLARYNGOLOGY AND AUDIOLOGY/SPEECH/LANGUAGE TESTS AND TREATMENTS (CODES V5299, V5362-V5364, 69000-69979, AND 92502-92599)

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 you 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 you 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.--Questions have been raised regarding whether or not the codes for these services--i.e., codes 92506, 92507, and 92508--are to be billed using time intervals. For example, are the codes to be billed at one unit of service for every 15 minutes of care provided or at one unit of service for every 30 minutes of care provided? The answer is no. 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.

15302. GROUP THERAPY SERVICES (CODE 97150)

Pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

15304. THERAPY STUDENTS

A. General.-- Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. Pay for the direct (one-to-one) patient contact services of the physician or therapist provided to Medicare Part B patients. Group therapy services performed by a therapist or physician may be billed when a student is also present "in the room".

Examples — Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgement, and is responsible for the assessment and treatment.

- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient of doing other tasks at the same time.

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

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

15350. DIALYSIS SERVICES (CODES 90935-90999)

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

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

B. Inpatient Dialysis On Same Date As Evaluation and Management.--Payment for certain evaluation and management services (CPT codes 99231 through 99233, subsequent hospital visits, and CPT codes 99261 through 99263, follow-up inpatient consultations) is considered bundled into the payment for inpatient dialysis (CPT codes 90935 through 90947) when both are performed on the same day by the same physician for the same beneficiary. Do not pay a physician for both dialysis and a subsequent hospital visit or a follow-up inpatient consultation on the same date of service. If both are billed, pay the dialysis service and deny the evaluation and management service.

Separate payment may be made for an initial hospital visit (CPT codes 99221 through 99223), an initial inpatient consultation (CPT codes 99251 through 99255), and a hospital discharge service (CPT codes 99238 and 99239) when billed for the same date as an inpatient dialysis service. These services may be billed with a modifier -25 to indicate that they are significant and identifiable services.

Payment is not allowed for more than one inpatient dialysis service per day.

15360. ECHOCARDIOGRAPHY SERVICES (CODES 93303 - 93350)

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

15400. CHEMOTHERAPY ADMINISTRATION (CODES 96400-96549)

A. General Use of Codes.--Chemotherapy administration codes, 96400 through 96450, 96542, 96545, and 96549, are only to be used when reporting chemotherapy administration when the drug being used is an antineoplastic and the diagnosis is cancer. The administration of other drugs,

such as growth factors, saline, and diuretics, to patients with cancer, or the administration of antineoplastics to patients with a diagnosis other than cancer, are reported with codes 90780 through 90784 as appropriate.

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

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

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

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

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

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

A. Use Of CPT Codes.--Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician

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

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

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

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

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

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

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