Program Memorandum Intermediaries/Carriers

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

Transmittal AB-01-182 **Date: DECEMBER 13, 2001**

This Program Memorandum re-issues Program Memorandum AB-00-126, Change Request 1415 dated December 15, 2000. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1415

SUBJECT: **Use of the American Medical Association's (AMA's) Physicians' Current Procedural Terminology, Fourth Edition (CPT) Codes on Contractors' Web Sites**

CMS and the AMA signed an amendment to the original 1983 Agreement on CMS's use of CPT coding. This new amendment covers the use of CPT codes, descriptions, and other materials on contractors' Web sites and in other electronic media. (For purposes of this Program Memorandum (PM) electronic media is defined as tapes, disk, or CD-ROM.) Effective 6 weeks (unless other wise specified in Part V) after the receipt of this PM, you must follow the requirements and guidelines below for any new or revised material being put on the your Web sites and electronic media.

Part I--Displaying of Material With CPT Codes

You now have the authority to include on your Web sites and in electronic media CPT code information in the following types of publications:

- Local medical review policies (LMRPs)
- Bulletins/newsletters
- Program Memoranda and instructions
- Coverage issues and Medicare coding policies
- Program Integrity Bulletins and information
- Educational training materials, including computer basic training modules
- Fee schedules
- Special mailings (contain information that would otherwise be included in the aforementioned publications, but due to time constraints requires expedited handling)

The above materials are referred to collectively as "Publications" whether displayed on an Internet Web site or included in electronic media.

Publications must be designed to convey Medicare specific information and not CPT coding advice. Publications must not be designed to substitute for the CPT Book with respect to codes, long descriptions, notes, or guidelines for any user.

In addition, when providing copies of publications in electronic media to any requesters in order to comply with Freedom of Information Act (FOIA) request; the publications you release via FOIA that contain CPT codes must only contain short descriptions. CPT short descriptions mean CPT five digit identifying code numbers and abbreviated procedural descriptions that are no more than 28 characters long. When you provide any electronic media to other State and Federal agencies any CPT coding contained in the publication(s) must conform to the requirements of this PM. You must notify such Federal and State agencies that their use is subject to the terms of the amendment.

Part II--Use of CPT Codes With Long Descriptors

CPT long descriptions mean CPT five digit identifying code numbers and complete procedural descriptions. CPT codes are considered the Level I codes in HCPCS. CPT codes are numeric and NOT alpha-numeric. CPT codes and long descriptions can be used on your Web sites as long as each document does not contain over 30 percent of a section (i.e., first level section heading in the CPT book table of contents, e.g., Surgery) or subsection (i.e., a second level heading in the table of contents, e.g., Surgery: Integumentary System) of the CPT-4 book. For example, in the CPT section Surgery, subsection "Hemic and Lympathic Systems", the total codes in this subsection are 47. If you need to display the codes and long descriptions, you would be able to list only 14 codes and long descriptions (30 percent). For any subsection that contains less than 30 CPT codes, this requirement does NOT apply.

Some CPT sections have subsections with only a few codes. For these CPT sections, i.e., Anesthesia, Evaluation and Management, and Pathology and Laboratory, the subsection limitation does not apply. The limit on the use of long descriptions is 30 percent of a total section.

Attachment I , contains a list of sections and subsections of CPT and the number of codes in each subsection. This attachment will be updated by the AMA and supplied to you by CMS on an annual basis as an attachment to the annual PM on HCPCS. (Note that Attachment I is an Excel File and is included as a separate document.)

If necessary, over 30 percent of a section of codes with their long descriptions may be used if the long descriptions are integrated into narrative text. The codes and long descriptions cannot be presented in consecutive listings even if used to convey fee schedule or payment policy information. (Attachment II provides an example of long descriptions and codes integrated into text.)

Remember that the 30 percent rule applies only to CPT codes with long descriptions. You may use as many CPT codes, or CPT codes and short descriptions as you want.

You are not permitted to use over 30 percent of a subsection of CPT-4 codes with long descriptions. AMA states that in doing so CMS is violating the AMA's copyright in CPT. As stated above, if over 30 percent of CPT-4 codes and long descriptions are used in a particular document, the long descriptions must be part of a narrative text (that are necessary for the presentation of information in that text and are not presented in consecutive listings) as in Attachment II. There may be circumstances where you believe the 30 percent rule should be waived. CMS and the AMA will deal with these situations on a case by case basis. If such a case occurs, contact your regional office who will communicate the case to central office (CO) for evaluation.

Fee schedules cannot include long descriptions. Only CPT short descriptions (28 characters or less) can be used in fee schedules.

For purposes of calculating the percent of "use" of CPT long descriptions as permitted herein, each distinct document, such as an individual issue of a publication, must be evaluated separately.

Part III--Distinguishing CPT and Non-CPT Material

CPT and non-CPT information must be clearly distinguished. CPT must be presented in such a way that it is clear to the reader what is CPT and what is not. Whenever practical, distinguish CPT by including the requirements of copyright notices, separation of CPT and non-CPT via distinct sections, formatting, font, or the like. We have developed examples of formats for display of CPT in publications as required by the amendment. Attachment III lists examples of formats to use when displaying CPT and non-CPT information or when distinguishing CPT and HCPCS level II notes and guidelines. You can also develop other formats as long as they distinguish between CPT and non-CPT information and between CPT and HCPCS level II notes or guidelines and meet the requirements of the amendment.

Part IV--Required Notices

A. AMA Copyright Notice

You must display the AMA copyright notice on the first screen or Web page of any document containing one or more CPT codes immediately prior to the initial appearance or display of any CPT. The copyright notice must also appear on the first page of publications of downloaded materials that include CPT. In other words, where any CPT code is used in publications on the Internet Web sites and other electronic media such as tape, disk or CD-ROM, whether short or long descriptions are used or only codes or ranges, you must display the AMA copyright notice. The copyright notice is:

CPT *codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply.*

NOTE: For your information FARS/DFARS is defined as FARS—Federal Acquisition Regulation System and DFARS—Defense Federal Acquisition Regulation Supplement.

B. Point and Click License

In addition, you must use a point and click license (a license that appears on a computer screen or Web page and includes a computer program or Web page mechanism that requires users to indicate whether they accept the terms of the license by pointing their cursor and clicking that they accept the terms of the license prior to accessing a document containing CPT). Whenever publications containing CPT are used on the Internet, an end user agreement in the form of a point and click license is required. (See Attachment IV.) It is your option to use a point and click license prior to each document containing CPT codes, or before initial access to any pages containing CPT codes at your Web site section level. **For example, you might put the point and click license before the Local Medical Review Policies with the following statement: *"Please read and accept the terms of the agreement below in order to proceed to the Policy Index and Policy Tests."*** You may include additional terms in the point and click license as long as the additional terms do not conflict with the requirements of this PM.

You must use a point and click license before each downloaded file that contains CPT codes. See CMS's Web site as an example: http://www.cms.hhs.gov/stats/rvucrst.htm.

The following statement must also appear on the Web page where the actual publication appears after the point and click license (e.g., as per http://www.cms.hhs.gov/stats/revdnlod.htm).

NOTE: Should you have landed here as a result of a search engine (or other) link, be advised that these files contain material that is copyrighted by the American Medical Association. You are forbidden to download the files unless you read, agree to, and abide by the provisions of the copyright statement. Read the copyright statement now and you will be linked back to here.

Computer based training modules that function as software must include an embedded point and click license if the training material contains CPT codes, descriptions or CPT notes, and guidelines. The module must include a mechanism that requires the acceptance of the license before installation of the program.

For electronic media such as tapes, diskettes, and CD ROMs, you must include either a point and click license which can be embedded in the diskettes or CD-ROM and accepted by the requester before the requester can access the files or a shrink-wrap license (Attachment V) Since a user does not sign a shrink-wrap license or take any other action like clicking acceptances as in the "point and click" license, a notice must be posted in a conspicuous location to encourage the reading of the agreement before opening the electronic media. The notice must read as follows:

> ***"Although this Publication is not copyrighted, it contains CPT, which is copyrighted by the American Medical Association (AMA). Carefully read the following AMA terms and conditions before opening the Electronic Media Package. Opening this package acknowledges your acceptance of the AMA terms and conditions. If you do not agree with these provisions, you must, within a reasonable time, return the Electronic Media Package unused."***

Part V--Effective Dates For Compliance and Application of the Amendment

Compliance with this PM is as follows:

As stated in the beginning of this PM, effective 6 weeks after the date of this instruction, any newly issued or revised LMRPs and other publications, that will be posted on your Web site must conform to the requirements of this instruction.

Bulletins, and/or newsletters posted on your Web site prior to the date of this PM need NOT comply with this instruction as long as the applicable copyright notice is displayed.

LMRPs and publications, other than bulletins or newsletters, posted on your Internet Web site prior to the date of this PM must conform with the requirements of the PM within 12 months

All end of year hard copy bulletins or newsletters that are issued containing the new, revised, or deleted CPT codes and long descriptions for the following new year must be edited to delete the long descriptions when putting these publications on your Web site.

In no event may the publications be designed to substitute for the CPT book for any user.

You may not charge for distribution over the Internet for publications(s) that include over 30 percent of a section or subsection of CPT, except that training materials that include CPT distributed over the Internet may be distributed for no more than cost of the materials.

The amendment authorizes use of CPT only for purposes related to CMS programs. Electronic and Internet distribution of materials containing CPT codes and descriptions, notes, or guidelines that are unrelated to CMS programs, including but not limited to, incorporation of CPT into commercial products requires a separate license agreement with the AMA.

Upon written request by any contractor that entered into a prior agreement with the AMA regarding the use of CPT codes on their Medicare Web site, the AMA will cancel the agreement so that the contractor can follow the requirements of this instruction.

The AMA/CMS Amendment can be viewed on two Web sites:

http://www.cms.hhs.gov/whatsnew/or www.cms.hhs.gov/medlearn.

These instructions should be implemented within your current operating budget. Funding has been provided in your current operating budget through the ongoing provider education and training activities and ongoing medical review activities.

This *effective date* of this PM is December 15, 2000.

The *implementation date* of this PM is as listed under Part V.

This Program Memorandum may be discarded after December 31, 2002.

Contractors should contact the appropriate regional office with any questions. Regional office staff can address questions to the following CO staff: Patricia Gill (for Part B carriers) on (410) 786-1297, Barbara Strickland (Part A intermediaries) on (410) 786-0508.

5 Attachments

ATTACHMENT I

CPT 2000 and 2001 SECTION COUNTS—See the Separate Excel File

ATTACHMENT II

EXAMPLE: CPT LONG DESCRIPTIONS INCORPORATED INTO NARRATIVE

Subject: Dialysis Shunt Maintenance Revised Medical Policy

CPT CODES:

35475, 35476, 35903, 36005, 36140,36145, 36215, 36216, 36217, 35245, 36246, 36247, 36489, 36491, 36535, 36800, 36810, 36815, 36821, 36825, 36830, 36831, 36832, 36833, 36834, 36835, 36860, 36861, 37201, 37202, 37205, 37206, 37207, 37208, 37607, 37799, 75710, 75820, 75896, 75898, 75960, 75962, 75964, 75978, 76499, and 93900

Indications and Limitation of Coverage and/or Medical Necessity

Percutaneous interventions to enhance or reestablish patency of a hemodialysis AV fistula have proven useful in extending the life of the fistula, and reducing the need for open repair, reconstruction, or replacement. The longevity and quality of the life of the end stage renal disease (ESRD) patient are positively impacted. Covered services are only indicated to correct a physiologically and functionally significant deficit of shunt performance. Percutaneous AV fistula declotting, maintenance, or reestablishment of appropriate and adequate flow may encompass the following procedures. These need not all be performed on every dysfunctional shunt. Each may, under unique circumstances, be considered reasonable and medically necessary.....

Open surgical therapy for thrombosed dialysis cannula or hemodynamically significant flow impediment utilizes direct access to the conduit and contiguous vessels. Mechanical fragmentation and surgical removal of occlusive thrombotic material is effected under direct visualization. Adjunctive thrombolytic pharmacotherapy may be employed. Residual vascular stenoses or obstructive lesions are removed and corrected using standard vascular surgical techniques; *e.g., CPT Code 36832, Revision, arteriovenous fistula; without thrombectomy, autogenous or non-autogenous dialysis graft {separate procedure}. 36834, Plastic repair arteriovenous aneurysm {separate procedure}.*

ATTACHMENT III

EXAMPLE 1: SEPARATION OF CPT AND NON-CPT INFORMATION

Subject: Consultations

CPT CODES: 99241-99243, 99244-99255

For implementation August 26, 1999, revision to Medicare Carriers Manual, Part 3 - Claims Process, Section 4142: Consultations, CMS concurs with American Medical Association *Current Procedural Terminology (CPT)* guidelines related to physician reporting of inpatient and outpatient consultation services 99241-99243, 99244-99255:

99241 Office consultation for a new or established patient, which requires these three key components:

- *a problem focused history;*
- *a problem focused examination; and*
- *straightforward medical decision making*

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99242 Office consultation for a new or established patient, which requires these three key components:

- *an expanded problem focused history;*
- *an expanded problem focused examination; and*
- *straightforward medical decision making*

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

Medicare Carriers Manual, Claims Review and Adjudication Procedures, transmittal number 1644 dated August 1999, has been revised to recognize consultations for application of special coverage of utilization criteria. In accordance with section 2020D, CMS will pay a consultation fee when the service is provided by a physician at the request of the patient's attending physician; all of the criteria for the use of a consultation code are met; the consultation is followed by treatment; the consultation is requested by members of the same group practice; the documentation for consultations has been met (written request from an appropriate source and a written report furnished the requesting physician); pre-operative consultation for a new or established patient performed by any physician at the request of the surgeon; and a surgeon requests that another physician participate in post-operative care (provided that the physician did not perform a pre-operative consultation).

EXAMPLE 2: DISTINGUISHING CPT AND HCPCS NOTES AND GUIDELINES

Subject: Issues Related to Critical Care Policy

This Program Memorandum (PM) is to clarify a number of issues related to the interpretation, reporting and payment of American Medical Association's (AMA) Current Procedural Terminology (CPT) critical care codes *99291 and 99292.* The clarifications pertain mainly to the changes in critical care definitions in the CPT 2000. Several policies in this PM are already in effect and are mentioned here again.

1. Use of the critical care CPT codes 99291 and 99292

(A) Definition of Critical Illness or Injury

The AMA's CPT has redefined a critical illness or injury as follows:

"A critical illness or injury acutely impairs one or more vial organ systems such that the patients survival is jeopardized."

Please note that the term "unstable" is no longer used in the CPT definition to describe critically ill or injured patients.

(B) Definition of Critical Care Services

CPT 2000 has redefined critical care services as follows:

"Critical care is the direct delivery by a physician(s) of medical care for a critically ill or injured patient..... the care of such patients involves decision making of high complexity to assess, manipulate, and support central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications, overwhelming infection, or other vial system functions to treat single or multiple vital organ system failure or to prevent further deterioration. It may require extensive interpretation of multiple databases and application of advanced technology to manage the patient. Critical care may be provided on multiple days, even if o changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above."

"Critical care services include but are not limited to, the treatment or prevention of further deterioration of central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic or respiratory failure, post operative complications, or overwhelming infection. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility."

(C) Guidelines for Use Whenever Medical Review is Performed in Relation to Critical Illness and Critical Care Service

A clarification of Medicare policy concerning both payment for and medical review of critical care services is warranted, given the CPT redefinition of both critical illness/injury and critical care services.

In order to reliably and consistently determine that delivery of critical care services rather than other evaluation and management services is medically necessary, both of the following medical review criteria must be met in addition to the CPT definitions.

Clinical Condition Criterion

There is a high probability of sudden, clinically significant, or life threatening deterioration in the patient's condition which requires the highest level of physician preparedness to intervene urgently.

Treatment Criterion

Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant, or life threatening deterioration in the patient's condition.

Claims for critical care services must be denied if the services are not reasonable and medically necessary. If the services are reasonable and medically necessary but they do not meet the criteria for critical care services, then the services should be re-coded as another appropriate evaluation and management (E/M) service (e.g., hospital visit).

Providing medical care to a critically ill patient should not be automatically determined to be a critical care service for the sole reason that the patient is critically ill. The physician service must be medically necessary and meet the definition of critical care services as described previously in order to be covered.

EXAMPLE 3: SEPARATION OF CPT AND NON-CPT CODES AND SHORT DESCRIPTIONS IN A FEE SCHEDULE OR SIMILAR LISTING

REVISED 2000 National Physician Fee Schedule Relative Value File

HCPCS/CPT	DESCRIPTION	STATUS CODE	WORK RVU
10040	Acne surgery of skin abscess	A	1.18
10060	Drainage of skin abscess	A	1.17
10061	Drainage of skin abscess	A	2.4
10080	Drainage of pilonidal cyst	A	1.17
10081	Drainage of pilonidal cyst	A	2.45
10120	Remove foreign body	A	1.22
10121	Remove foreign body	A	2.69
10140	Drainage of hematoma/fluid	A	1.53
10160	Puncture drainage of lesion	A	1.2
10180	Complex drainage, wound	A	2.25
11000	Debride infected skin	A	0.6
11001	Debride infected skin add-on	A	0.3
11010	Debride skin, fx	A	4.2
11011	Debride skin/muscle, fx	A	4.95
11012	Debride skin/muscle/bone, fx	A	6.88
11040	Debride skin, partial	A	0.5
11041	Debride skin, full	A	0.82
11042	Debride skin/tissue	A	1.12
11043	Debride tissue/muscle	A	2.38
11044	Debride tissue/muscle/bone	A	3.06
11055	Trim skin lesion	R	0.27
11056	Trim skin lesions, 2 to 4	R	0.39
11057	Trim skin lesions, over 4	R	0.5
11100	Biopsy of skin lesion	A	0.81
11101	Biopsy, skin add-on	A	0.41
11200	Removal of skin tags	A	0.77
V5299	Hearing service	R	0
V5336	Repair communication device	N	0
V5362	Speech screening	R	0
V5363	Language screening	R	0
V5364	Dysphagia screening	R	0

(Example shows separation of CPT codes from alpha-numeric codes)

ATTACHMENT IV

LICENSE FOR USE OF "PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY", (CPT) FOURTH EDITION

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