Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1511

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2001*
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Section 15047, Preoperative Services Paid Under the Physician Fee Schedule, is added to clarify payment policy for preoperative evaluations obtained outside of the global surgical period, and establishes a clear hierarchy for denying such services.

Carriers should delete any processing edits that deny claims or identify for manual review ICD codes V72.81 through V72.84. Claims containing these codes are subject to medical necessity determinations as described in §15047. H.

These instructions should be implemented within your current operating budget.

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.

CHAPTER XV
FEE SCHEDULE FOR PHYSICIANS' SERVICES

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procedure codes on the same date, apply the bilateral adjustment before applying any applicable multiple procedure rules.

C. Bilateral Surgery Indicator Equals 2.--The fee schedule amounts for these services were established as bilateral services because (a) the code description specifically states that the procedure is bilateral; (b) the code description states that the procedure may be performed either bilaterally or unilaterally; or 8 the procedure is typically performed as a bilateral procedure. Therefore, the bilateral adjustment does not apply.

Base payment on the lower of (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single procedure if the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field). This represents payment for the procedure performed on both sides of the body.

EXAMPLE: The fee schedule amount for code CCCCC is $125. The physician reports codes CCCCC-LT and CCCCC-RT with an actual charge of $100 for each code. Base payment on $125 because it is lower than the actual charges for the procedure done on both left and right sides ($200).

D. Bilateral Surgery Indicator Equals 3.--Base payment for each procedure on the lower of (a) the actual charge for both sides or (b) 100 percent of the fee schedule for each procedure if the code is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units column). The usual payment adjustment for bilateral procedures does not apply. Services in this category are generally radiology procedures or other diagnostic tests.

EXAMPLE: The fee schedule amount for code DDDDD is $125. The physician reports code DDDDD-LT and DDDDD-RT with an actual charge of $100 for each code. Base payment on $200 because it is the lower of the actual charge or the fee schedule amount ($250) for both procedures.

E. Bilateral Surgery Indicator Equals 9.--The concept does not apply. For example, visit codes cannot be bilateral.

15044. ASSISTANT AT SURGERY SERVICES

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

Do not pay assistants at surgery for surgical procedures in which a physician is used as an assistant at surgery in fewer than 5 percent of the cases for that procedure nationally. Use EOMB message 23.14 in §7012 to deny payment for the assistant at surgery services listed.

In addition to the assistant at surgery modifiers 80, 81, or 82, any procedures submitted with modifiers AK, AL, AM, AN, AS, AU, AV, AW, AY, QB, or QU are subject to the assistant surgeon's policy enunciated in the Medicare physician fee schedule data base (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 limit. Physicians who knowingly and willfully violate this prohibition and bill a beneficiary for an assistant at surgery service for these procedures codes may be subject to the penalties contained under §1842(j)(2) of the Act.

15046. CO-SURGEONS/SURGICAL TEAM

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.

15047. PREOPERATIVE SERVICES

A. General.--This manual instruction addresses payment for preoperative services that are not included in the global surgery payment. Sections 4820 and 4821 of the Medicare Carriers Manual (MCM) describe the preoperative care that is included in the global surgery payment.

B. Non-global Preoperative Services.--Consist of evaluation and management (E/M) services (preoperative examinations) that are not included in the global surgical package and diagnostic tests performed for the purpose of evaluating a patient’s risk of perioperative complications and optimizing perioperative care. Medicare will pay for all medically necessary preoperative services as described in §15047, subsections C and D.

C. Non-global Preoperative Examinations.--E/M services performed that are not included in the global surgical package for the purpose of evaluating a patient’s risk of perioperative complications and to optimize perioperative care. Preoperative examinations may be billed by using an appropriate CPT code (e.g., new patient, established patient, or consultation). Such non-global preoperative examinations are payable if they are medically necessary and meet the documentation and other requirements for the service billed.

D. Preoperative Diagnostic Tests.--Tests performed to determine a patient’s perioperative risk and optimize perioperative care. Preoperative diagnostic tests are payable if they are medically necessary and meet any other applicable requirements.

E. Statutory Basis for Payment.--

1. Section 1862(a)(7) of the Social Security Act (the Act) excludes payment for “routine physical checkups.” Both physical examinations and diagnostic tests that are performed in the absence of signs or symptoms of illness or injury may be denied as a routine physical checkup under §1862(a)(7) of the Act. The regulatory provision that further explains this policy is contained in 42 CFR Part 411.15(a)(1).

2. Section 1862(a)(1)(A) of the Act states that no payment will be made for “items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” Both physical examinations and diagnostic tests performed in the absence of signs or symptoms can be denied as unnecessary under §1862(a)(1)(A) of the Act.

3. Through previous program and decision memoranda, Medicare has established a clear hierarchy in the application of these two statutory provisions for use in denying payment for physical examinations and diagnostic tests. Claims are initially evaluated against the statutory requirements of §1862(a)(7) of the Act and, if not denied on that basis, they are evaluated against the statutory requirements of §1862 (a)(1)(A). If they meet the statutory requirements of §1862(a)(1)(A) of the Act, they are paid. In general, §1862(a)(1)(A) of the Act is to be invoked only for denying payment for services that are otherwise covered, and are not otherwise excluded from payment, but which are not covered in a particular case because they are not deemed “medically reasonable and necessary” when performed in that specific situation.

F. Applicability of §1862(a)(7) of the Act to Preoperative Services.--

1. Preoperative Examinations.--For purposes of billing under the Physician Fee Schedule, medical preoperative examinations performed by, or at the request of, the attending surgeon does not fall within the statutory exclusion articulated in §1862(a)(7) of the Act. These examinations are payable if they are medically necessary (i.e., based on a determination of medical necessity under §1862(a)(1)(A) of the Act), and meet the documentation requirements of the service billed. Determination of the appropriate E/M code is based on the requirements of the specific type and level of visit or consultation the physician submits on his claim (e.g., established patient, new patient, consultation).

2. Preoperative Diagnostic Tests.--When billing under the Physician Fee Schedule, preoperative diagnostic tests performed by, or at the request of, the physician performing preoperative examinations, do not fall within the statutory exclusion articulated in §1862(a)(7) of the Act. These diagnostic tests are payable if they are medically necessary (i.e., they may be denied under §1862(a)(1)(A)).

G. ICD Coding Requirements for Preoperative Services.--All claims for preoperative medical examination and preoperative diagnostic tests (i.e., preoperative medical evaluations) must be accompanied by the appropriate ICD-9 code for preoperative examination (e.g., V72.81 through V72.84). Additionally, the appropriate ICD-9 code for the condition(s) that prompted surgery must also be documented on the claim. Other diagnoses and conditions affecting the patient should also be documented on the claim, if appropriate. The ICD-9 code that appears in the line item of a preoperative examination or diagnostic test must be the code for the appropriate preoperative examination (e.g., V72.81 through V72.84).

H. Medical Necessity Determination.--Medical necessity for specific preoperative services is determined by any applicable national coverage decisions. In the absence of a national coverage determination, medical necessity is determined by carrier discretion.

15048. PURCHASED DIAGNOSTIC TESTS

A. General.--Section 1842(n) of the Act establishes payment rules for diagnostic tests billed by a physician but performed by an outside supplier. For this purpose, diagnostic tests are tests covered under §1861(s)(3) of the Act other than clinical diagnostic laboratory tests. These include, but are not limited to, such tests as X-rays, EKGs, EEGs, cardiac monitoring, ultrasound, and the technical component of physician pathology services furnished on or after January 1, 1994. Physician pathology services are the services described in §§15022.B and C. (Note that screening mammography services are covered under another provision of the Act and are not subject to the purchased services limitation.) These rules apply to the test itself (the TC) and not to physicians' services associated with the test.

B. Payment.--If a test is personally performed by a physician or is supervised by a physician, such physician may bill under the normal physician fee schedule rules. This includes situations in which the test is performed or supervised by another physician with whom the billing physician shares a practice. For this purpose, services under a physician's supervision has the same meaning as is required for services to be considered incident to a physician's service (see §2050.1), i.e., direct supervision of the physician's own employees or of his or her medical group which constitutes a physician directed clinic under §2050.3. The supervision requirement is not met when the test is administered by supplier personnel regardless of whether the test is performed at the physician's office or at another location. In addition, for the supervision requirement to be met, the personnel must be employed by the physician or by his or her medical group in his, her, or its medical practice. The fact that a physician may have an ownership interest in the outside supplier is not material to this determination, and employees of such supplier are not considered the physician's employees for purposes of this provision.

If a physician bills for a diagnostic test performed by an outside supplier, the fee schedule amount for the purchased service equals the lower of the billing physician's fee schedule or the price he or she paid for the service. The lower figure is the fee schedule amount for purposes of the limiting charge. (See §17002.) The billing physician must identify the supplier (including the supplier's provider number) and the amount the supplier charged the billing physician (net of any discounts). A physician who accepts assignment is permitted to bill and collect from the beneficiary only the applicable deductible and coinsurance for the purchased test. A physician who does not accept assignment is permitted to bill and collect from the beneficiary only the fee schedule amount (as defined above) for the purchased test. The limiting charge provision is not applicable.

If the physician does not identify the supplier and provide the other required information, no payment is allowed, and the physician may not bill the beneficiary any amount for the test.

C. Sanctions.--Physicians who knowingly and willfully, in repeated cases, bill Medicare beneficiaries amounts beyond those outlined in §15048.B are subject to the penalties contained under §1842(j)(2) of the Act.

D. Questionable Business Arrangements.--Section 15048.B imposes no special charge or payment constraints on tests performed by a physician or a physician's employees under his or her supervision. However, attempts may be made by the medical diagnostic community to adjust or establish arrangements which continue to allow physicians to profit from other's work or by creating the appearance that the physician has performed or supervised his/her employees' performance of the service. Some of these arrangements may involve cardiac scanning services and mobile ultrasound companies leasing their equipment to physicians for the day the equipment is used and hiring out their staff to the physicians to meet the supervision requirement.

The bonafides of these arrangements are extremely suspect. HCFA views this arrangement as a transparent attempt to circumvent the prohibition against the mark-up on purchased diagnostic tests. The mere issuance of a W-2 from the physician does not automatically make the leasing company's technician the physician's employee for purposes of our employer-employee test. Rather, the determination as to a valid employer-employee relationship is dependent upon factors such as who has the right to hire and fire, who trains the employee, who is paying health and retirement benefits, who schedules work, who approves sick and vacation time, and so forth. If you have any doubt that a particular arrangement is a valid employer-employee relationship and/or believe that a physician is billing for a purchased diagnostic test in excess of the amount permitted, refer the case to the Office of the Inspector General (OIG) for investigation as a potential violation of §1842(n) of the Act.

Another arrangement to circumvent the purchased diagnostic service provision is for the ordering physician to reassign his/her payment for the interpretation of the test to the supplier. The supplier, in turn, bills for both the test and the interpretation and pays the ordering physician a fee for the interpretation. This arrangement violates §1842(b)(6) of the Act, which prohibits Medicare from paying benefits due the person that furnished the service to any other person, subject to limited exceptions discussed in §3060.D. Also, this arrangement could constitute a violation of §1128 B (b) of the Act, which prohibits remuneration for referrals (i.e., kickbacks).

Violations of §1128B (b) of the Act may subject the physician or supplier to criminal penalties or exclusion from the Medicare and Medicaid programs. Illegal remuneration for referrals can be found even when the ordering physician performs some service for the remuneration.

15050. ALLERGY TESTING AND IMMUNOTHERAPY

A. Allergy Testing.--Allergy testing services billed under codes 95004-95078 are paid under the Medicare fee schedule for physician services using the national RVUs included in the data base. The RVUs shown for each code are per test. Therefore, instruct physicians to show the quantity of tests provided when billing. Multiply the payment for one test by the quantity for the code.

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 HCFA-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. You are no longer to recognize and physicians are no longer to use the J antigen codes (i.e., J0220, J0230, J0240, J7010, and J7020) or CPT codes 95120 through 95134. 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. You are to recognize and physicians are to bill only the component codes, i.e., the injection only codes (i.e., codes 95115 and 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170). Pay physicians billing for only the injection service the appropriate code 95115 or code 95117 allowance. Pay physicians billing for only an antigen/antigen preparation service for the appropriate code in the range from 95144 through 95170. Pay physicians providing both services both the injection and the antigen/antigen preparation allowance. This includes allergists who provide both services through the use of treatment boards. They will no longer use the complete service codes and instead are to bill and be paid for both the injection and the antigen services separately, even though the current CPT definitions of the antigen codes refer to vials and the physicians using treatment boards do not create vials.

3. If a physician bills both an injection code plus either codes 95165 or 95144, 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, 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

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