Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev. 2464, 05-04-12)

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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:

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

Where:

RVUw equals a relative value for physician work,

RVUpe equals a relative value for practice expense, and

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

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

RVUw = 0

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

RVUm = .01

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

RVUpe = 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 RVUpe 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.

GPCIw = 0.994

GPCIpe = 0.912

GPCIm = 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.

Payment = (RVUw x GPCIw + (RVUpe x GPCIpe) + RVUm + GPCIm x physician fee schedule payment.

Payment = (0 x .994) + (2.92 x .927) + (.01 x .912) x $166.52 =

Payment = (0) + (2.70684) + (.00912) x 166.52

Payment = $452.26166 or $452.26 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. 1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

For services prior to January 1, 1994, B/MACs 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;
- Anti-Markup Payment Limitation;
- 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, 9994 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. 1604, Issued: 09-26-08, Effective: 01-08-08, Implementation: 01-05-09)

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.

Place of service code (POS) is used to identify where the procedure is furnished. The list of facilities where a physician's professional services are paid at the facility rate 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);
    - In an approved ambulatory surgical center (ASC) for a HCPCS code included on the ASC approved list of procedures (POS code 24); and
    - In a Medicare-approved ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24)

Physicians' professional services are paid at nonfacility rates for procedures furnished:

- In SNFs to Part B residents - (POS code 32);
- In a patient's home (POS code 12); and
    - In a facility or institution other than a hospital, skilled nursing facility, community mental health center or ASC (POS codes 49 or 99).

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 procedures 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 serviced 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. 2464, Issued: 05-04-12, Effective: 10-01-11-MCS/10-01-12-VMS, Implementation: 10-03-11-MCS, VMS Analysis and Design /10-01-12-VMS implementation)

The CMS provides updates to the MPFSDB and other fee schedules annually or as otherwise necessary. Claims processing contractors must maintain at least five full calendar years of fee schedules and related pricing data (i.e., the current and four prior calendar years), regardless of the number of updates or pricing periods within those five years.

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.

20.8 - Payment for Teleradiology Physician Services Purchased by the Indian Health Service (IHS) Providers and Physicians

(Rev. 1643, Issued: 12-05-08, Effective: 01-01-07, Implementation: 03-09-09)

The IHS providers may choose to purchase or otherwise contract with non-IHS physicians or practitioners for teleradiology interpretations services. These services may be paid using either contractual reassignment or purchased test methodologies. See Chapter 19, §120 of this manual for further information.

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 - Audiology Services

(Rev. 2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

Section 1861(ll)(3)of the Social Security Act (the Act) defines "audiology services" as such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise by covered if furnished by a physician. In this section, these hearing and balance assessment services are termed "audiology services," regardless of whether they are furnished by an audiologist, physician, nonphysician practitioner (NPP), or hospital.

Because audiology services are diagnostic tests, when furnished in an office or hospital outpatient department, they must be furnished by or under the appropriate level of supervision of a physician as established in 42 CFR 410.32(b)(1) and 410.28(e). If not personally furnished by a physician, audiologist, or NPP, audiology services must be

performed under direct physician supervision. As specified in 42 CFR 410.32(b)(2)(ii) or (v), respectively, these services are excepted from physician supervision when they are personally furnished by a qualified audiologist or performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable State laws.

References to technicians apply also to other qualified clinical staff. See Pub. 100-02, chapter 15, section 80.3.D.

A - Correct Reporting

1. General. Contact the contractor for guidance if the CPT codebook changes the description of codes mentioned in this section.

Other policies concerning audiological services are found in Pub. 100-02, chapter 15, section 80.3.

See chapter 26 of this manual for place of service and type of service coding.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33), which added section 1834(k)(5) to (the Act), required that all claims for certain audiology services be reported using a uniform coding system. CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system for the reporting of these services. This coding requirement is effective for all claims for audiology services submitted on or after April 1, 1998.

The BBA also required payment under a prospective payment system for audiology services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for audiology services furnished in the office setting and for the associated professional services furnished in physician's office and hospital outpatient settings.

2. Use of the NPI. For audiologists who are enrolled and bill independently for services they render, the audiologist's NPI is required on all claims they submit. For example, in offices and private practice settings, an enrolled audiologist shall use his or her own NPI in the rendering loop to bill under the MPFS for the services the audiologist furnished. If an enrolled audiologist furnishing services to hospital outpatients reassigns his/her benefits to the hospital, the hospital may bill the carrier or Medicare administrative contractor for the professional services of the audiologist under the MPFS using the NPI of the audiologist. If an audiologist is employed by a hospital but is not enrolled in Medicare, the only payment for a hospital outpatient audiology service that can be made is the payment to the hospital for its facility services under the hospital Outpatient Prospective Payment System (OPPS) or other applicable hospital payment system. No payment can be made under the MPFS for professional services of an audiologist who is not enrolled.

Audiologists must be enrolled and use their NPI on claims for services they render in office settings on or after October 1, 2008 (for additional information about enrollment, refer to Pub. 100-08, Medicare Program Integrity Manual, chapter 15). Before October 1, 2008, the services of audiologists who were not yet enrolled in Medicare were billed by a physician or group who employed the audiologist. Audiologists shall use the billing instructions in the Medicare manuals; for example, see this manual, chapter 1, section 30.

See the most recent MPFS for pricing and physician supervision levels for audiology services: http://www.cms.hhs.gov/PFSlookup/01_Overview.asp#TopOfPage. The NPI of the supervising physician shall be used to bill audiology services when supervision is appropriate.

The most recent OPPS pricing for audiology services is available in Addendum B at: http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage.

B. Billing for Audiology Services

See the CMS Web site at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp for a listing of all CPT codes for audiology services. For information concerning codes that are not on the list, and which codes may be billed when furnished by technicians, contractors shall provide guidance. The Physician Fee Schedule at http://www.cms.gov/PFSlookup/01_Overview.asp#TopOfPage allows you to search pricing amounts, various payment policy indicators, RVUs, and GPCIs.

Audiology services may not be billed when the place of service is a comprehensive outpatient rehabilitation facility (CORF) or a rehabilitation agency.

Audiology services may be furnished and billed by audiologists and, when these services are furnished by an audiologist, no physician supervision is required.

The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision. Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component if the audiology service has a professional component/technical component split.

1. Billing under the MPFS for Audiology Services Outside the Facility Setting

The individuals who furnish audiology services in all settings must be qualified to furnish those services. The qualifications of the individual performing the services must be consistent with the number, type and complexity of the tests, the abilities of the individual, and the patient's ability to interact to produce valid and reliable results. The physician who supervises and bills for the service is responsible for assuring the qualifications of the technician, if applicable are appropriate to the test.

a. Professional Skills.

When a professional personally furnishes an audiology service, that individual must interact with the patient to provide professional skills and be directly involved in decision-making and clinical judgment during the test.

The skills required when professionals furnish audiology services for payment under the MPFS are masters or doctoral level skills that involve clinical judgment or assessment and specialized knowledge and ability including, but not limited to, knowledge of anatomy and physiology, neurology, psychology, physics, psychometrics, and interpersonal communication. The interactions of these knowledge bases are required to attain the clinical expertise for audiology tests. Also required are skills to administer valid and reliable tests safely, especially when they involve stimulating the auditory nerve and testing complex brain functions.

Diagnostic audiology services also require skills and judgment to administer and modify tests, to make informed interpretations about the causes and implications of the test results in the context of the history and presenting complaints, and to provide both objective results and professional knowledge to the patient and to the ordering physician.

Examples include, but are not limited to:

- Comparison or consideration of the anatomical or physiological implications of test results or patient responsiveness to stimuli during the test;
- Development and modification of the test battery and test protocols;
- Clinical judgment, assessment, evaluation, and decision-making;
- Interpretation and reporting observations, in addition to the objective data, that may influence interpretation of the test outcomes;
- Tests related to implantation of auditory prosthetic devices, central auditory processing, contralateral masking; and/or
- Tests to identify central auditory processing disorders, tinnitus, or nonorganic hearing loss.

Audiology codes may be billed under the MPFS by audiologists, physicians, and NPPs using their own NPI in the rendering loop when those professionals personally furnish the test. Physicians and NPPs may not bill for these codes when an audiologist has furnished the service.

b. Technician Skills.

There may be subtests, or parts of a battery of tests, that may be appropriately furnished by an educated and experienced technician using a specific protocol under the direction of a supervising physician. These services are identified by local contractor determination as services that do not require professional skills. They may be furnished by a qualified technician under the direct supervision of a physician, but not under the supervision of an audiologist or an NPP. The supervising physician is responsible for rendering and documenting all clinical judgment and for the appropriate provision of the service by the technician.

A technician may not perform any part of a service that requires professional skills. A technician also may not perform a global service. For example, a technician may not interpret test results or engage in clinical decision-making.

c. Professional Component (PC)/Technical Component (TC) Split Codes.

- The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service. A physician or NPP may not bill for a PC service furnished by an audiologist.

- The TC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. Physicians may bill the TC for services furnished by technicians when the technician furnishes the service under the direct supervision of that physician. Audiologists and NPPs may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.

- The "global" service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may also be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report.

d. <u>Tests that are Not Described by Specific CPT Codes</u>. Tests that have no appropriate CPT code may be reported under CPT code 92700 (Unlisted otorhinolaryngological service or procedure).

e. <u>Tests that are Contractor-Priced.</u> For codes valued by contractors, the contractor determines whether and how much, if applicable, to pay for the service. The contractor sets the requirements for personnel furnishing the tests.

2. <u>Billing for Audiology Services Furnished to Hospital Outpatients.</u>

All codes may be reported for audiology services furnished in the hospital outpatient setting and, in such cases, the code represents the facility service for the diagnostic test. All audiology services furnished to hospital outpatients must be billed and paid to the hospital under the OPPS or other applicable hospital payment system. The hospital bills its fiscal intermediary or Medicare administrative contractor (A/B MAC) and is paid for the facility resources required to furnish the services, regardless of whether the service is furnished by a physician, NPP, audiologist, or technician.

Physicians, NPPs, and audiologists cannot bill and be paid for the TC of PC/TC split codes when these services are furnished to hospital outpatients. The associated professional services (represented by the PC or the CPT code for the audiology test which has no PC/TC split) of an enrolled audiologist, physician, or NPP who has reassigned benefits may be billed by the hospital to the carrier or A/B MAC, as appropriate. Alternatively, if the physician, NPP, or audiologist has not assigned benefits, the professional would bill his/her carrier or A/B MAC for the professional services furnished.

The appropriate revenue code for reporting audiology services is 0470 (Audiology; General Classification). Providers are required to report a line-item date of service per revenue code line for audiology services.

3. Billing for Audiology Services Furnished to Skilled Nursing Facility (SNF) Patients.

Payment for the facility resources (including the TC of PC/TC split codes) of audiology services provided to Part A inpatients of SNFs is included in the PPS rate. For SNFs, if the beneficiary has Part B but not Part A coverage (e.g., Part A benefits are exhausted), the SNF may elect to bill for audiology services but is not required to do so. As explained in Pub. 100-04, chapter 7, section 40.1, since audiology services furnished during a noncovered SNF stay are not bundled with speech-language pathology services, payment can be made either to the SNF or to the audiology service provider/supplier.

Audiologists, physicians, and NPPs enrolled in Medicare may bill directly for services rendered to Medicare beneficiaries who are in a SNF stay that is not covered by Part A but who have Part B eligibility. Payment is made based on the MPFS, whether on an institutional or professional claim. For beneficiaries in a noncovered SNF stay, audiology services are payable under Part B when billed by the SNF on an institutional claim as type of bill 22X, or when billed directly by the provider or supplier of the service (the audiologist, physician, or NPP who personally furnishes the test) on a professional claim. For PC/TC split codes, the SNF may elect to bill for the TC of the test on an institutional claim but is not required to bill for the service.

C - Implant Processing

Payment for diagnostic testing of implants, such as cochlear, osseointegrated or brainstem implants, including programming or reprogramming following implantation surgery is not included in the global fee for the surgery.

The diagnostic analysis of a cochlear implant shall be billed using CPT codes 92601 through 92604.

Osseointegrated prosthetic devices should be billed and paid for under provisions of the applicable payment system. For example, payment may differ depending upon whether the device is furnished on an inpatient or outpatient basis, and by a hospital subject to the OPPS, or by a Critical Access Hospital, physician's clinic, or a Federally Qualified Health Center.

D - Aural Rehabilitation Services

General policy for evaluation and treatment of conditions related to the auditory system.

For evaluation of auditory processing disorders and speech-reading or lip-reading by a speech-language pathologist, use the untimed code 92506 with "1" as the unit of service, regardless of the duration of the service on a given day. This "always therapy" evaluation code must be provided by speech-language pathologists according to the policies in Pub. 100-02, chapter 15, sections 220 and 230. The codes 92620 and 92621 are diagnostic audiological tests and may not be used for SLP services.

For treatment of auditory processing disorders or auditory rehabilitation/auditory training (including speech-reading or lip-reading), 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. These codes always represent SLP services. See Pub. 100-02, chapter 15, sections 220 and 230 for SLP policies. These SLP evaluation and treatment services are not covered when performed or billed by audiologists, even if they are supervised by physicians or qualified NPPs.

For evaluation of auditory rehabilitation to instruct the use of residual hearing provided by an implant or hearing aid related to hearing loss, the timed codes 92626 and 92627 are used. These are not "always therapy" codes. Evaluation of auditory rehabilitation shall be appropriately provided and billed by an audiologist or speech-language pathologist. Also, these services may be provided incident to a physician's or qualified NPP's service by a speech-language pathologist, or personally by a physician or qualified NPP within their scope of practice. Evaluation of auditory rehabilitation is a covered diagnostic test when performed and billed by an audiologist and is an SLP evaluation service covered under the SLP benefit when performed by a speech-language pathologist.

General policies for post implant services.

The services of a speech-language pathologist may be covered for SLP services provided after implantation of auditory devices. For example, a speech-language pathologist may provide evaluation and treatment of speech, language, cognition, voice, and auditory processing using code 92506 and 92507. Use 92626 and 92627 for auditory (aural)

rehabilitation evaluation following cochlear implantation or for other hearing impairments.

For diagnostic testing of cochlear implants, audiologists use codes 92601, 92602, 92603 and 92604. These services may not be provided by speech-language pathologists or others, with the exception of physicians and NPPs who may personally provide the services that are within their scope of practice.

30.4 - Cardiovascular System (Codes 92950-93799)

(Rev. 979, Issued: 06-09-06, Effective: 07-10-06, Implementation: 07-10-06)

A. Echocardiography Contrast Agents

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.

B. Electronic Analyses of Implantable Cardioverter-defibrillators and Pacemakers

The CPT codes 93731, 93734, 93741 and 93743 are used to report electronic analyses of single or dual chamber pacemakers and single or dual chamber implantable cardioverter-defibrillators. In the office, a physician uses a device called a programmer to obtain information about the status and performance of the device and to evaluate the patient's cardiac rhythm and response to the implanted device.

Advances in information technology now enable physicians to evaluate patients with implanted cardiac devices without requiring the patient to be present in the physician's office. Using a manufacturer's specific monitor/transmitter, a patient can send complete device data and specific cardiac data to a distant receiving station or secure Internet server. The electronic analysis of cardiac device data that is remotely obtained provides immediate and long-term data on the device and clinical data on the patient's cardiac functioning equivalent to that obtained during an in-office evaluation. Physicians should report the electronic analysis of an implanted cardiac device using remotely obtained data as described above with CPT code 93731, 93734, 93741 or 93743, depending on the type of cardiac device implanted in the patient.

30.5 - Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions

(Rev. 968. Issued: 05-26-06; Effective/Implementation Dates: 06-26-06)

A. General

Codes for Chemotherapy administration and nonchemotherapy injections and infusions include the following three categories of codes in the American Medical Association's Current Procedural Terminology (CPT):

1. Hydration;

2. Therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy); and

3. Chemotherapy administration.

Physician work related to hydration, injection, and infusion services involves the affirmation of the treatment plan and the supervision (pursuant to incident to requirements) of nonphysician clinical staff.

B. Hydration

The hydration codes are used to report a hydration IV infusion which consists of a pre-packaged fluid and /or electrolytes (e.g. normal saline, D5-1/2 normal saline +30 mg EqKC1/liter) but are not used to report infusion of drugs or other substances.

C. Therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy)

A therapeutic, prophylactic, or diagnostic IV infusion or injection, other than hydration, is for the administration of substances/drugs. The fluid used to administer the drug (s) is incidental hydration and is not separately payable.

If performed to facilitate the infusion or injection or hydration, the following services and items are included and are not separately billable:

1. Use of local anesthesia;

2. IV start;

3. Access to indwelling IV, subcutaneous catheter or port;

4. Flush at conclusion of infusion; and

5. Standard tubing, syringes and supplies.

Payment for the above is included in the payment for the chemotherapy administration or nonchemotherapy injection and infusion service.

If a significant separately identifiable evaluation and management service is performed, the appropriate E & M code should be reported utilizing modifier 25 in addition to the chemotherapy administration or nonchemotherapy injection and infusion service. For an evaluation and management service provided on the same day, a different diagnosis is not required.

The CPT 2006 includes a parenthetical remark immediately following CPT code 90772 (Therapeutic, prophylactic or diagnostic injection; (specify substance or drug);

subcutaneous or intramuscular.) It states, "Do not report 90772 for injections given without direct supervision. To report, use 99211."

This coding guideline does not apply to Medicare patients. If the RN, LPN or other auxiliary personnel furnishes the injection in the office and the physician is not present in the office to meet the supervision requirement, which is one of the requirements for coverage of an incident to service, then the injection is not covered. The physician would also not report 99211 as this would not be covered as an incident to service.

D. Chemotherapy Administration

Chemotherapy administration codes apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers. The following drugs are commonly considered to fall under the category of monoclonal antibodies: infliximab, rituximab, alemtuzumb, gemtuzumab, and trastuzumab. Drugs commonly considered to fall under the category of hormonal antineoplastics include leuprolide acetate and goserelin acetate. The drugs cited are not intended to be a complete list of drugs that may be administered using the chemotherapy administration codes. Local carriers may provide additional guidance as to which drugs may be considered to be chemotherapy drugs under Medicare.

The administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration.

If performed to facilitate the chemotherapy infusion or injection, the following services and items are included and are not separately billable:

1. Use of local anesthesia;

2. IV access;

3. Access to indwelling IV, subcutaneous catheter or port;

4. Flush at conclusion of infusion;

5. Standard tubing, syringes and supplies; and

6. Preparation of chemotherapy agent(s).

Payment for the above is included in the payment for the chemotherapy administration service.

If a significant separately identifiable evaluation and management service is performed, the appropriate E & M code should be reported utilizing modifier 25 in addition to the chemotherapy code. For an evaluation and management service provided on the same day, a different diagnosis is not required.

E. Coding Rules for Chemotherapy Administration and Nonchemotherapy Injections and Infusion Services

Instruct physicians to follow the CPT coding instructions to report chemotherapy administration and nonchemotherapy injections and infusion services with the exception listed in subsection C for CPT code 90772. The physician should be aware of the following specific rules.

When administering multiple infusions, injections or combinations, the physician should report only one "initial" service code unless protocol requires that two separate IV sites must be used. The initial code is the code that best describes the key or primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code should be reported. For example, the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code.

If more than one "initial" service code is billed per day, the carrier shall deny the second initial service code unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol. For these separately identifiable services, instruct the physician to report with modifier 59.

The CPT includes a code for a concurrent infusion in addition to an intravenous infusion for therapy, prophylaxis or diagnosis. Allow only one concurrent infusion per patient per encounter. Do not allow payment for the concurrent infusion billed with modifier 59 unless it is provided during a second encounter on the same day with the patient and is documented in the medical record.

For chemotherapy administration and therapeutic, prophylactic and diagnostic injections and infusions, an intravenous or intra-arterial push is defined as: 1.) an injection in which the healthcare professional is continuously present to administer the substance/drug and observe the patient; or 2.) an infusion of 15 minutes or less.

The physician may report the infusion code for "each additional hour" only if the infusion interval is greater than 30 minutes beyond the 1 hour increment. For example if the patient receives an infusion of a single drug that lasts 1 hour and 45 minutes, the physician would report the "initial" code up to 1 hour and the add-on code for the additional 45 minutes.

Several chemotherapy administration and nonchemotherapy injection and infusion service codes have the following parenthetical descriptor included as a part of the CPT code, "List separately in addition to code for primary procedure." Each of these codes has a physician fee schedule indicator of "ZZZ" meaning this service is allowed if billed with another chemotherapy administration or nonchemotherapy injection and infusion service code.

Do not interpret this parenthetical descriptor to mean that the add-on code can be billed only if it is listed with another drug administration primary code. For example, code

90761 will be ordinarily billed with code 90760. However, there may be instances when only the add-on code, 90761, is billed because an "initial" code from another section in the drug administration codes, instead of 90760, is billed as the primary code.

Pay for code 96523, "Irrigation of implanted venous access device for drug delivery systems," if it is the only service provided that day. If there is a visit or other chemotherapy administration or nonchemotherapy injection or infusion service provided on the same day, payment for 96523 is included in the payment for the other service.

F. Chemotherapy Administration (or Nonchemotherapy Injection and Infusion) and Evaluation and Management Services Furnished on the Same Day

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 or a chemotherapy administration code. Apply this policy to code 99211 when it is billed with a diagnostic or therapeutic injection code on or after January 1, 2005.

Physicians providing a chemotherapy administration service or a nonchemotherapy drug infusion service and evaluation and management services, other than CPT code 99211, on the same day must bill in accordance with §30.6.6 using modifier 25. The carriers pay for evaluation and management services provided on the same day as the chemotherapy administration services or a nonchemotherapy injection or infusion service if the evaluation and management service meets the requirements of section §30.6.6 even though the underlying codes do not have global periods. If a chemotherapy service and a significant separately identifiable evaluation and management service are provided on the same day, a different diagnosis is not required.

In 2005, the Medicare physician fee schedule status database indicators for therapeutic and diagnostic injections were changed from T to A. Thus, beginning in 2005, the policy on evaluation and management services, other than 99211, that is applicable to a chemotherapy or a nonchemotherapy injection or infusion service applies equally to these codes.

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. 1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

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

Contractors must advise physicians that to bill the highest levels of visit 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.

30.6.1.1 – Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

A. Definitions

1. Initial Preventive Physical Examination (IPPE)

The initial preventive physical examination (IPPE), or "Welcome to Medicare Visit" (WMV) is a preventive evaluation and management service (E/M), allowed by Section 611 of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, that includes:

(1) review of the individual's medical and social history with attention to modifiable risk factors for disease detection,

(2) review of the individual's potential (risk factors) for depression or other mood disorders,

(3) review of the individual's functional ability and level of safety,

(4) a physical examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the examining physician or qualified nonphysician practitioner (NPP),

(5) performance and interpretation of an electrocardiogram (EKG),

(6) education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous 5 elements, and,

(7) education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services.

Effective January 1, 2007, Section 5112 of the Deficit Reduction Act of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysm (AAA), HCPCS code G0389, as a result of a referral from an IPPE. This service is not subject to the Part B annual deductible. For AAA physician/practitioner billing, correct coding, and payment policy, refer to chapter 18, §110, of this manual.

Effective January 1, 2009, Section 101 (b) of the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 requires the addition of the measurement of an individual's body mass index and, upon an individual's consent, end-of-life planning, to the IPPE. Also, effective January 1, 2009, MIPPA removes the screening electrocardiogram (EKG) as a mandatory service of the IPPE. MIPPA requires that there be education, counseling, and referral for an EKG, as appropriate. This is a once-in-a-lifetime screening EKG as a result of a referral from an IPPE.

The MIPPA of 2008 allows for possible future payment for additional preventive services not otherwise described in Title XVIII of the Social Security Act (the Act) that identify medical conditions or risk factors for eligible individuals if the Secretary determines through the national coverage determination (NCD) process (as defined in Section 1869(f)(1)(B) of the Act) that they are: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B, or both. MIPPA requires that there be education, counseling, and referral for additional preventive services, as appropriate, under the IPPE, if the Secretary determines in the future that such services are covered.

2. Annual Wellness Visit (AWV)

Effective January 1, 2011, Section 4103 of the Affordable Care Act (ACA), allows for a preventive physical examination, called the annual wellness visit (AWV), and includes personal prevention plan services (PPPS). The AWV is a new annual Medicare preventive physical examination, available for eligible beneficiaries, and identified by new HCPCS codes G0438 (Annual wellness visit, including PPPS, first visit) and G0439 (Annual wellness visit, including PPPS, subsequent visit). Definitions relative to the AWV are included at Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.5.

First AWV services providing PPPS (HCPCS G0438) are a 'one time' allowed Medicare benefit and include the following key elements furnished to an eligible beneficiary by a health professional:

- Establishment of the individual's medical/family history,
- Measurement of the individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure (BP), and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual,
- Detection of any cognitive impairment that the individual may have,
- Review of an individual's potential risk factors for depression , including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations,

- Review of the individual's functional ability and level of safety, based on direct observation of the individual, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations,

- Establishment of a written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the USPSTF and Advisory Committee of Immunizations Practices (ACIP), the individual's health status, screening history, and age-appropriate preventive services covered by Medicare,

- Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits,

- Provision of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition, and,

- Any other element(s) determined appropriate by the Secretary through the NCD process.

Subsequent AWV services providing PPPS (HCPCS G0439) include the following key elements furnished to an eligible beneficiary by a health professional:

- Update to the individual's medical /family history,

- Measurements of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical and family history,

- Update to the list of the individual's current medical providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first AWV providing PPPS,

- Detection of any cognitive impairment that the individual may have,

- Update to the individual's written screening schedule as developed at the first AWV providing PPPS,

- Update to the individual's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, as that list was developed at the first AWV providing PPPS,

- Furnish appropriate personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs, and,

- Any other element determined appropriate by the Secretary through the NCD process.

Preventive services are separately covered under Medicare Part B. See chapter 18 of this manual.

B. Who May Perform

The IPPE and the AWV may be performed by a doctor of medicine or osteopathy as defined in Section 1861(r) (1) of the Act, by a qualified NPP (nurse practitioner, physician assistant or clinical nurse specialist), or for the AWV, by a health professional (a medical professional including a health educator, registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals who are working under the direct supervision of a physician. The contractor pays the appropriate physician fee schedule amount based on the rendering National Provider Identification (NPI) number.

C. Eligibility

1. IPPE

As a result of the MMA 2003, Medicare will pay for one IPPE per beneficiary per lifetime. A beneficiary is eligible when he/she first enrolls in Medicare Part B. For beneficiaries enrolled on or after January 1, 2005, beneficiaries must have received their IPPE within the first 6 months of Medicare coverage. The MIPPA extends the eligibility period for an IPPE to 12 months effective January 1, 2009.

Beneficiaries in their first 12 months of Part B coverage will continue to be eligible for only the IPPE. Medicare continues to pay for only one IPPE per beneficiary per lifetime.

2. AWV

As a result of the ACA, effective January 1, 2011, Medicare will pay for an AWV for a beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and he/she has not received either an IPPE or an AWV providing PPPS within the past 12 months. Medicare pays for only one first AWV

(HCPCS G0438), per beneficiary per lifetime, and all subsequent wellness visits must be billed as a subsequent AWV (HCPCS G0439).

Beneficiaries in their first 12 months of Part B coverage will continue to be eligible for only the IPPE (see 30.6.1.1.A.1).

D. Deductible and Coinsurance

1. IPPE

The Medicare deductible and coinsurance apply for the IPPE provided before January 1, 2009.

The Medicare deductible is waived effective for the IPPE provided on or after January 1, 2009. However, the applicable coinsurance continues to apply for the IPPE provided on or after January 1, 2009.

As a result of the ACA, effective for the IPPE provided on or after January 1, 2011, the Medicare deductible and coinsurance (for HCPCS code G0402 only) are waived.

2. AWV

As a result of the ACA, effective January 1, 2011, the Medicare deductible and coinsurance for the AWV (HCPCS G0438 and G0439) are waived.

E. The EKG Component of the IPPE

Under the MMA of 2003, if the physician or qualified NPP is not able to perform both the examination and the screening EKG, an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate HCPCS G code(s) identified in F.1. of this section. When the screening EKG is performed, the primary physician or qualified NPP shall document the results of the screening EKG into the beneficiary's medical record to complete and bill for the IPPE benefit.

NOTE: Both components of the IPPE (the examination and the screening EKG) must be performed before the claims can be submitted by the physician, qualified NPP, and/or entity.

MIPPA 2008 changes the once-in-a-lifetime screening EKG from a mandated service to a service that may be performed, as appropriate, with a referral from an IPPE. When an EKG is furnished with the IPPE, the deductible and coinsurance will continue to apply for EKG services only.

F. HCPCS Codes Used to Bill the IPPE or AWV

1. HCPCS Codes Used to Bill the IPPE

For IPPE and EKG services provided prior to January 1, 2009, the physician or qualified NPP shall bill HCPCS code G0344 for the physical examination performed face-to-face, and HCPCS code G0366 for performing a screening EKG that includes both the interpretation and report. If the primary physician or qualified NPP performs only the examination, he/she shall bill HCPCS code G0344 only. The physician or entity that performs the screening EKG that includes both the interpretation and report shall bill HCPCS code G0366. The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0367. The physician or entity that performs the interpretation and report only (without the EKG tracing) shall bill HCPCS code G0368. Medicare will pay for a screening EKG only as part of the IPPE. HCPCS codes G0344, G0366, G0367 and G0368 will not be billable codes effective on or after January 1, 2009.

Effective for a beneficiary who has the IPPE on or after January 1, 2009, and within his/her 12-month enrollment period of Medicare Part B, the IPPE and screening EKG services are billable with the appropriate HCPCS G code(s).

The physician or qualified NPP shall bill HCPCS code G0402 for the physical examination performed face-to-face with the patient.

The physician or entity shall bill HCPCS code G0403 for performing the complete screening EKG that includes the tracing, interpretation and report.

The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0404.

The physician or entity that performs the screening EKG interpretation and report only, (without the EKG tracing) shall bill HCPCS code G0405.

2. HCPCS Codes Used to Bill the AWV

For the first AWV provided on or after January 1, 2011, the health professional shall bill HCPCS G0438 (Annual wellness visit, including PPPS, first visit). This is a once per beneficiary per lifetime allowable Medicare benefit.

All subsequent AWVs shall be billed with HCPCS G0439 (Annual Wellness Visit, including PPPS, subsequent visit). In the event that a beneficiary selects a new health professional to complete a subsequent AWV, the new health professional will continue to bill the subsequent AWV with HCPCS G0439.

NOTE: For an IPPE or AWV performed during the global period of surgery refer to chapter 12, §30.6.6 of this manual for reporting instructions.

G. Documentation for the IPPE or AWV

The physician and qualified NPP, or for AWV the health professional, shall use the appropriate screening tools typically used in routine physician practice. Physicians, qualified NPPs, and medical professionals are required to use the 1995 and 1997 E/M documentation guidelines to document the medical record with the appropriate clinical information. (http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp). All referrals and a written medical plan must be included in this documentation.

H. Reporting a Medically Necessary E/M Service Furnished During the Same Encounter as an IPPE or AWV

When the physician or qualified NPP, or for AWV the health professional, provides a significant, separately identifiable medically necessary E/M service in addition to the IPPE or an AWV, CPT codes 99201 – 99215 may be reported depending on the clinical appropriateness of the circumstances. CPT Modifier –25 shall be appended to the medically necessary E/M service identifying this service as a significant, separately identifiable service from the IPPE or AWV code reported (HCPCS code G0344 or G0402, whichever applies based on the date the IPPE is performed, or HCPCS code G0438 or G0439 whichever AWV code applies).

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the IPPE or AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

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. 954, Issued: 05-19-06, Effective: 06-01-06, Implementation: 08-20-06)

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

Medicare requires that Current Procedural Terminology (CPT) modifier -25 should only be used on claims for evaluation and management (E/M) services, and only when these services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or other service. Carriers pay for an E/M 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 E/M service that is above and beyond the usual pre- and post-operative work of the procedure. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier -25 is added to the E/M code on the claim.

Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified nonphysician practitioner in the

patient's medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.

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 no 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 or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215)

(Rev. 731, Issued: 10-28-05, Effective: 01-01-04 Chemotherapy and Non-Chemotherapy drug infusion codes/01-01-05 Therapeutic and Diagnostic injection codes, Implementation: 01-03-06)

A Definition of New Patient for Selection of E/M Visit Code

Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. 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 E/M service or other face-to-face service with the patient 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 E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

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

As for all other E/M services except where specifically noted, carriers may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) 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 E/M 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. Bundle E/M visits 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 Drug Administration Services and E/M Visits Billed on Same Day of Service

Carriers must advise physicians that CPT code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code (effective January 1, 2004). This drug administration policy was expanded in the Physician Fee Schedule Final Rule, November 15, 2004, to also include a therapeutic or diagnostic injection code (effective January 1, 2005). Therefore, when a medically necessary, significant and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of these drug administration services, the appropriate E/M CPT code should be reported with modifier -25. Documentation should support the level of E/M service billed. For an E/M service provided on the same day, a different diagnosis is not required.

30.6.8 - Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services)

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

A. Who May Bill Observation Care Codes

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Contractors pay for initial observation care billed by only the physician who ordered hospital outpatient observation services and was responsible for the patient during his/her observation care. A physician who does not have inpatient admitting privileges but who is authorized to furnish hospital outpatient observation services may bill these codes.

For a physician to bill observation care codes, there must be a medical observation record for the patient which contains dated and timed physician's orders regarding the observation services the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient received observation services. 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 ordering physician on the date the patient's observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

For example, if an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial and subsequent observation care codes. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate.

For information regarding hospital billing of observation services, see Chapter 4, §290.

B. Physician Billing for Observation Care Following Initiation of Observation Services

Similar to initial observation codes, payment for a subsequent observation care code is for all the care rendered by the treating physician on the day(s) other than the initial or

discharge date. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

When a patient receives observation care for less than 8 hours on the same calendar date, the Initial Observation Care, from CPT code range 99218 – 99220, shall be reported by the physician. The Observation Care Discharge Service, CPT code 99217, shall not be reported for this scenario.

When a patient is admitted for observation care and then is discharged on a different calendar date, the physician shall report Initial Observation Care, from CPT code range 99218 – 99220, and CPT observation care discharge CPT code 99217. On the rare occasion when a patient remains in observation care for 3 days, the physician shall report an initial observation care code (99218-99220) for the first day of observation care, a subsequent observation care code (99224-99226) for the second day of observation care, and an observation care discharge CPT code 99217 for the observation care on the discharge date. When observation care continues beyond 3 days, the physician shall report a subsequent observation care code (99224-99226) for each day between the first day of observation care and the discharge date.

When a patient receives observation care for a minimum of 8 hours, but less than 24 hours, and is discharged on the same calendar date, Observation or Inpatient Care Services (Including Admission and Discharge Services) from CPT code range 99234 – 99236 shall be reported. The observation discharge, CPT code 99217, cannot also be reported for this scenario.

C. Documentation Requirements for Billing Observation or Inpatient Care Services (Including Admission and Discharge Services)

The physician shall satisfy the E/M documentation guidelines for furnishing observation care or inpatient hospital care. In addition to meeting the documentation requirements for history, examination, and medical decision making, documentation in the medical record shall include:

- Documentation stating the stay for observation care or inpatient hospital care involves 8 hours, but less than 24 hours;

- Documentation identifying the billing physician was present and personally performed the services; and

- Documentation identifying the order for observation services, progress notes, and discharge notes were written by the billing physician.

In the rare circumstance when a patient receives observation services for more than 2 calendar dates, the physician shall bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes. The physician may

not use the subsequent hospital care codes since the patient is not an inpatient of the hospital.

D. Admission to Inpatient Status Following Observation Care

If the same physician who ordered hospital outpatient observation services also admits the patient to inpatient status before the end of the date on which the patient began receiving hospital outpatient observation services, 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 or subsequent 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 hospital outpatient observation care subsequent to the date of initiation of observation services, 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 while the patient received hospital outpatient observation services on the date of admission to inpatient status.

E. Hospital Observation Services During Global Surgical Period

The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, and 99236) services unless the criteria for use of CPT modifiers "-24," "-25," or "-57" are met. Contractors 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:

- An emergency department physician orders hospital outpatient observation services for a patient with a head injury. A neurosurgeon is called in to evaluate the need for surgery while the patient is receiving observation services and decides that the patient requires surgery. The surgeon would bill a new or established office or other outpatient visit code as appropriate with the "-57" modifier to indicate that the decision for surgery was made during the evaluation. The surgeon must bill the office or other outpatient visit code because the patient receiving hospital outpatient observation services is not an inpatient of the hospital. Only the physician who ordered hospital outpatient observation services may bill for observation care.

- A neurosurgeon orders hospital outpatient observation services for a patient with 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 surgeon orders hospital outpatient observation services for a patient with abdominal pain from a kidney stone on the 80th day following a TURP (performed by that surgeon). 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 surgeon orders hospital outpatient observation services for a patient with abdominal pain on the 80th day following a TURP (performed by that surgeon). While the patient is receiving hospital outpatient observation services, 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 receiving hospital outpatient observation services. The subsequent surgical procedure would be reported with modifier "-79."

- A surgeon orders hospital outpatient observation services for a patient with abdominal pain on the 20th day following a resection of the colon (performed by that surgeon). 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 when a physician repairs a laceration of the scalp in the emergency department for a patient with a head injury and then subsequently orders hospital outpatient observation services for that patient. 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

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

A. Hospital Visit and Critical Care on Same Day

When a hospital inpatient or office/outpatient evaluation and management service (E/M) are furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care both the critical Care Services (CPT

codes 99291 and 99292) and the previous E/M service may be paid on the same date of service. Hospital emergency department services are not paid for the same date as critical care services when provided by the same physician to the same patient.

During critical care management of a patient those services that do not meet the level of critical care shall be reported using an inpatient hospital care service with CPT Subsequent Hospital Care using a code from CPT code range 99231 – 99233.

Both Initial Hospital Care (CPT codes 99221 – 99223) and Subsequent Hospital Care codes are "per diem" services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.

Physicians and qualified nonphysician practitioners (NPPs) are advised to retain documentation for discretionary contractor review should claims be questioned for both hospital care and critical care claims. The retained documentation shall support claims for critical care when the same physician or physicians of the same specialty in a group practice report critical care services for the same patient on the same calendar date as other E/M services.

B. Two Hospital Visits Same Day

Contractors 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, contractors 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 and Observation or Inpatient Care Services (Including Admission and Discharge Services)

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

A. Initial Hospital Care From Emergency Room

Contractors pay for an initial hospital care service if a physician sees a 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

Contractors 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

When the patient is admitted to inpatient hospital care for less than 8 hours on the same date, then Initial Hospital Care, from CPT code range 99221 – 99223, shall be reported by the physician. The Hospital Discharge Day Management service, CPT codes 99238 or 99239, shall not be reported for this scenario.

When a patient is admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician shall report an Initial Hospital Care from CPT code range 99221 – 99223 and a Hospital Discharge Day Management service, CPT code 99238 or 99239.

When a patient has been admitted to inpatient hospital care for a minimum of 8 hours but less than 24 hours and discharged on the same calendar date, Observation or Inpatient Hospital Care Services (Including Admission and Discharge Services), from CPT code range 99234 – 99236, shall be reported.

D. Documentation Requirements for Billing Observation or Inpatient Care Services (Including Admission and Discharge Services)

The physician shall satisfy the E/M documentation guidelines for admission to and discharge from inpatient observation or hospital care. In addition to meeting the documentation requirements for history, examination and medical decision making documentation in the medical record shall include:

- Documentation stating the stay for hospital treatment or observation care status involves 8 hours but less than 24 hours;

- Documentation identifying the billing physician was present and personally performed the services; and

- Documentation identifying the admission and discharge notes were written by the billing physician.

E. 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:

- Different hospitals;

- Different facilities under common ownership which do not have merged records; or

- 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.

F. Initial Hospital Care Service History and Physical That Is Less Than Comprehensive

When a physician performs a visit that meets the definition of a Level 5 office visit 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 that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code 99221) for the initial hospital admission. Contractors pay the office visit as billed and the Level 1 initial hospital care code.

Physicians who provide an initial visit to a patient during inpatient hospital care that meets the minimum key component work and/or medical necessity requirements shall report an initial hospital care code (99221-99223). The principal physician of record shall append modifier "-AI" (Principal Physician of Record) to the claim for the initial hospital care code. This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care.

Physicians may bill initial hospital care service codes (99221-99223), for services that were reported with CPT consultation codes (99241 – 99255) prior to January 1, 2010, when the furnished service and documentation meet the minimum key component work and/or medical necessity requirements. Physicians must meet all the requirements of the initial hospital care codes, including "a detailed or comprehensive history" and "a detailed or comprehensive examination" to report CPT code 99221, which are greater than the requirements for consultation codes 99251 and 99252.

Subsequent hospital care CPT codes 99231 and 99232, respectively, require "a problem focused interval history" and "an expanded problem focused interval history." An E/M service that could be described by CPT consultation code 99251 or 99252 could potentially meet the component work and medical necessity requirements to report 99231 or 99232. Physicians may report a subsequent hospital care CPT code for services that were reported as CPT consultation codes (99241 – 99255) prior to January 1, 2010, where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

Reporting CPT code 99499 (Unlisted evaluation and management service) should be limited to cases where there is no other specific E/M code payable by Medicare that describes that service. Reporting CPT code 99499 requires submission of medical records and contractor manual medical review of the service prior to payment. Contractors shall expect reporting under these circumstances to be unusual.

G. Initial Hospital Care Visits by Two Different M.D.s or D.O.s When They Are Involved in Same Admission

In the inpatient hospital setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306). Contractors consider only one M.D. or D.O. to be the principal physician of record (sometimes referred to as the admitting physician.) The principal physician of record is identified in Medicare as the physician who oversees the patient's care from other physicians who may be furnishing specialty care. Only the principal physician of record shall append modifier "-AI" (Principal Physician of Record) in addition to the E/M code. Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.

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

(Rev. 1460, Issued: 02-22-08, Effective: 04-01-08, Implementation: 04-07-08)

A. Subsequent Hospital Visits During the Global Surgery Period

(Refer to §§40-40.4 on global surgery)

The Medicare physician fee schedule payment amount for surgical procedures includes all services (e.g., evaluation and management visits) that are part of the global surgery payment; therefore, contractors shall not pay more than that amount when a bill is fragmented for staged procedures.

B. Hospital Discharge Day Management Service

Hospital Discharge Day Management Services, CPT code 99238 or 99239 is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified nonphysician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is payable per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified nonphysician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (CPT code range 99231 – 99233) for a final visit.

Medicare pays for the paperwork of patient discharge day management through the pre- and post- service work of an E/M service.

C. 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, refer to §30.6.9.1 C for the policy on Observation or Inpatient Care Services (Including Admission and Discharge Services CPT Codes 99234 - 99236). Contractors 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.

D. 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

Contractors 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).

Contractors 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.

E. Hospital Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service, CPT code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed even if the paperwork is delayed to a subsequent date.

30.6.10 - Consultation Services

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

Consultation Services versus Other Evaluation and Management (E/M) Visits

Effective January 1, 2010, the consultation codes are no longer recognized for Medicare Part B payment. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed.

In the inpatient hospital setting and the nursing facility setting, physicians (and qualified nonphysician practitioners where permitted) may bill the most appropriate initial hospital care code (99221-99223), subsequent hospital care code (99231 and 99232), initial nursing facility care code (99304-99306), or subsequent nursing facility care code (99307-99310) that reflects the services the physician or practitioner furnished. Subsequent hospital care codes could potentially meet the component work and medical necessity requirements to be reported for an E/M service that could be described by CPT consultation code 99251 or 99252. Contractors shall not find fault in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay. Unlisted evaluation and management service (code 99499) shall only be reported for consultation services when an E/M service that could be described by codes 99251 or 99252 is furnished, and there is no other specific E/M code payable by Medicare that describes that service. Reporting code 99499 requires submission of medical records and contractor manual medical review of the service prior to payment. CMS expects reporting under these circumstances to be unusual. T he principal physician of record is identified in Medicare as the physician who oversees the

patient's care from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier "-AI" (Principal Physician of Record), in addition to the E/M code. Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.

In the CAH setting, those CAHs that use method II shall bill the appropriate new or established visit code for those physician and non-physician practitioners who have reassigned their billing rights, depending on the relationship status between the physician and patient.

In the office or other outpatient setting where an evaluation is performed, physicians and qualified nonphysician practitioners shall use the CPT codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician. All physicians and qualified nonphysician practitioners shall follow the E/M documentation guidelines for all E/M services. These rules are applicable for Medicare secondary payer claims as well as for claims in which Medicare is the primary payer.

30.6.11 - Emergency Department Visits (Codes 99281 - 99288)

(Rev. 1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

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. 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 an emergency department visit code. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.

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

(Rev. 1548, Issued: 07-089-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

CRITICAL CARE SERVICES (CODES 99291-99292)

A. Use of Critical Care Codes

Pay for services reported with CPT codes 99291 and 99292 when all the criteria for critical care and critical care services are met. Critical care is defined as the direct delivery by a physician(s) medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition.

Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.

Critical care is usually, but not always, given in a critical care area such as a 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.

Consult the American Medical Association (AMA) CPT Manual for the applicable codes and guidance for critical care services provided to neonates, infants and children.

B. Critical Care Services and Medical Necessity

Critical care services must be medically necessary and reasonable. Services provided that do not meet critical care services or services provided for a patient who is not critically ill or injured in accordance with the above definitions and criteria but who happens to be in a critical care, intensive care, or other specialized care unit should be reported using another appropriate E/M code (e.g., subsequent hospital care, CPT codes 99231 - 99233).

As described in Section A, critical care services encompass both treatment of "vital organ failure" and "prevention of further life threatening deterioration of the patient's

condition." Therefore, although critical care may be delivered in a moment of crisis or upon being called to the patient's bedside emergently, this is not a requirement for providing critical care service. The treatment and management of the patient's condition, while not necessarily emergent, shall be required, based on the threat of imminent deterioration (i.e., the patient shall be critically ill or injured at the time of the physician's visit).

Chronic Illness and Critical Care:

Examples of patients whose medical condition may not warrant critical care services:

1. Daily management of a patient on chronic ventilator therapy does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence.

2. Management of dialysis or care related to dialysis for a patient receiving ESRD hemodialysis does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long term management of the dialysis dependence (refer to Chapter 8, §160.4). When a separately identifiable condition (e.g., management of seizures or pericardial tamponade related to renal failure) is being managed, it may be billed as critical care if critical care requirements are met. Modifier –25 should be appended to the critical care code when applicable in this situation.

Examples of patients whose medical condition may warrant critical care services:

1. An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and pressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.

2. A 67 year old female patient is 3 days status post mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.

3. A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive 2 days after admission.

4. A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

Examples of patients who may not satisfy Medicare medical necessity criteria, or do not meet critical care criteria or who do not have a critical care illness or injury and therefore not eligible for critical care payment:

1. Patients admitted to a critical care unit because no other hospital beds were available;

2. Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose); and

3. Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

Providing medical care to a critically ill patient should not be automatically deemed to be a critical care service for the sole reason that the patient is critically ill or injured. While more than one physician may provide critical care services to a patient during the critical care episode of an illness or injury each physician must be managing one or more critical illness(es) or injury(ies) in whole or in part.

> **EXAMPLE**: A dermatologist evaluates and treats a rash on an ICU patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist. The dermatologist should not report a service for critical care.

C. Critical Care Services and Full Attention of the Physician

The duration of critical care services to be reported is the time the physician spent evaluating, providing care and managing the critically ill or injured patient's care. That time must be spent at the immediate bedside or elsewhere on the floor or unit so long as the physician is 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 may be reported as critical care, even when it does not occur at the bedside, if this time represents the physician’s full attention to the management of the critically ill/injured patient.

For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

D. Critical Care Services and Qualified Non-Physician Practitioners (NPP)

Critical care services may be provided by qualified NPPs and reported for payment under the NPP’s National Provider Identifier (NPI) when the services meet the definition and requirements of critical care services in Sections A and B. The provision of critical care services must be within the scope of practice and licensure requirements for the State in which the qualified NPP practices and provides the service(s). Collaboration, physician supervision and billing requirements must also be met. A physician assistant shall meet the general physician supervision requirements.

E. Critical Care Services and Physician Time

Critical care is a time- based service, and for each date and encounter entry, the physician's progress note(s) shall document the total time that critical care services were provided. More than one physician can provide critical care at another time and be paid if the service meets critical care, is medically necessary and is not duplicative care. Concurrent care by more than one physician (generally representing different physician specialties) is payable if these requirements are met (refer to the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, §30 for concurrent care policy discussion).

The CPT critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. Non-continuous time for medically necessary critical care services may be aggregated. Reporting CPT code 99291 is a prerequisite to reporting CPT code 99292. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician (§30.6.5).

1. Off the Unit/Floor

   Time spent in activities (excluding those identified previously in Section C) that occur outside of the unit or off the floor (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care because the physician is not immediately available to the patient. This time is regarded as pre- and post service work bundled in evaluation and management services.

2. Split/Shared Service

   A split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) cannot be reported as a critical care service. Critical care services are reflective of the care and management of a critically ill or critically injured patient by an individual physician or qualified non-physician practitioner for the specified reportable period of time.

   Unlike other E/M services where a split/shared service is allowed the critical care service reported shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified non-physician practitioner and shall not be representative of a combined service between a physician and a qualified NPP.

   When CPT code time requirements for both 99291 and 99292 and critical care criteria are met for a medically necessary visit by a qualified NPP the service shall be billed using the appropriate individual NPI number. Medically necessary visit(s) that do not meet these requirements shall be reported as subsequent hospital care services.

3. Unbundled Procedures

Time involved performing procedures that are not bundled into critical care (i.e., billed and paid separately) may not be included and counted toward critical care time. The physician's progress note(s) in the medical record should document that time involved in the performance of separately billable procedures was not counted toward critical care time.

4. Family Counseling/Discussions

Critical care CPT codes 99291 and 99292 include pre and post service work. Routine daily updates or reports to family members and or surrogates are considered part of this service. However, time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options (as described in CPT), may be counted toward critical care time when these specific criteria are met:

a) The patient is unable or incompetent to participate in giving a history and/or making treatment decisions, and

b) The discussion is necessary for determining treatment decisions.

For family discussions, the physician should document:

a. The patient is unable or incompetent to participate in giving history and/or making treatment decisions

b. The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family",

c. Medically necessary treatment decisions for which the discussion was needed, and

d. A summary in the medical record that supports the medical necessity of the discussion

All other family discussions, no matter how lengthy, may not be additionally counted towards critical care. Telephone calls to family members and or surrogate decision-makers may be counted towards critical care time, but only if they meet the same criteria as described in the aforementioned paragraph.

5. Inappropriate Use of Time for Payment of Critical Care Services.

Time involved in activities that do not directly contribute to the treatment of the critically ill or injured patient may not be counted towards the

critical care time, even when they are performed in the critical care unit at a patient's bedside (e.g., review of literature, and teaching sessions with physician residents whether conducted on hospital rounds or in other venues).

F. Hours and Days of Critical Care that May Be Billed

Critical care service is a time-based service provided on an hourly or fraction of an hour basis. Payment should not be restricted to a fixed number of hours, a fixed number of physicians, or a fixed number of days, on a per patient basis, for medically necessary critical care services. Time counted towards critical care services may be continuous or intermittent and aggregated in time increments (e.g., 50 minutes of continuous clock time or (5) 10 minute blocks of time spread over a given calendar date). Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient.

For Medicare Part B physician services paid under the physician fee schedule, critical care is not a service that is paid on a “shift” basis or a “per day” basis. Documentation may be requested for any claim to determine medical necessity. Examples of critical care billing that may require further review could include: claims from several physicians submitting multiple units of critical care for a single patient, and submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date. Physicians assigned to a critical care unit (e.g., hospitalist, intensivist, etc.) may not report critical care for patients based on a ‘per shift” basis.

The CPT code 99291 is used to report the first 30 - 74 minutes of critical care on a given calendar date of service. It should only be used once per calendar date per patient by the same physician or physician group of the same specialty. CPT code 99292 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes of critical care (See table below). Critical care of <u>less than 30 minutes total duration on a given calendar date</u> is not reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.

<u>Clinical Example of Correct Billing of Time</u>:

A patient arrives in the emergency department in cardiac arrest. The emergency department physician provides 40 minutes of critical care services. A cardiologist is called to the ED and assumes responsibility for the patient, providing 35 minutes of critical care services. The patient stabilizes and is transferred to the CCU. In this instance, the ED physician provided 40 minutes of critical care services and reports only the critical care code (CPT code 99291) and not also emergency department services. The cardiologist may report the 35 minutes of critical care services (also CPT code 99291) provided in the ED. Additional critical care services by the cardiologist in the CCU may be reported on the same calendar date using 99292 or another appropriate E/M code depending on the clock time involved.

G. Counting of Units of Critical Care Services

The CPT code 99291 (critical care, first hour) is used to report the services of a physician providing full attention to a critically ill or critically injured patient from 30-74 minutes on a given date. Only one unit of CPT code 99291 may be billed by a physician for a patient on a given date. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician and would not each report CPT 99291on the same date of service.

The following illustrates the correct reporting of critical care services:

Total Duration of Critical Care	**Codes**
Less than 30 minutes	99232 or 99233 or other appropriate E/M code
30 - 74 minutes	99291 x 1
75 - 104 minutes	99291 x 1 and 99292 x 1
105 - 134 minutes	99291 x1 and 99292 x 2
135 - 164 minutes	99291 x 1 and 99292 x 3
165 - 194 minutes	99291 x 1 and 99292 x 4
194 minutes or longer	99291 – 99292 as appropriate (per the above illustrations)

H. Critical Care Services and Other Evaluation and Management Services Provided on Same Day

When critical care services are required upon the patient's presentation to the hospital emergency department, only critical care codes 99291 - 99292 may be reported. An emergency department visit code may not also be reported.

When critical care services are provided on a date where an inpatient hospital or office/outpatient evaluation and management service was furnished earlier on the same date at which time the patient did not require critical care, both the critical care and the previous evaluation and management service may be paid. Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient.

Physicians are advised to submit documentation to support a claim when critical care is additionally reported on the same calendar date as when other evaluation and management services are provided to a patient by the same physician or physicians of the same specialty in a group practice.

I. Critical Care Services Provided by Physicians in Group Practice(s)

Medically necessary critical care services provided on the same calendar date to the same patient by physicians representing different medical specialties that are not duplicative services are payable. The medical specialists may be from the same group practice or from different group practices.

Critically ill or critically injured patients may require the care of more than one physician medical specialty. Concurrent critical care services provided by each physician must be medically necessary and not provided during the same instance of time. Medical record documentation must support the medical necessity of critical care services provided by each physician (or qualified NPP). Each physician must accurately report the service(s) he/she provided to the patient in accordance with any applicable global surgery rules or concurrent care rules. (Refer to Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, §40, and the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, §30.)

CPT Code 99291

The initial critical care time, billed as CPT code 99291, must be met by a single physician or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician on the same calendar date. A history or physical exam performed by one group partner for another group partner in order for the second group partner to make a medical decision would not represent critical care services.

CPT Code 99292

Subsequent critical care visits performed on the same calendar date are reported using CPT code 99292. The service may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty in order to meet the duration of minutes required for CPT code 99292. The aggregated critical care visits must be medically necessary and each aggregated visit must meet the definition of critical care in order to combine the times.

Physicians in the same group practice who have the same specialty may not each report CPT initial critical care code 99291 for critical care services to the same patient on the same calendar date. Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician. (Refer to the Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, §30.6.)

Physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the contractor that adjudicates the claims. Physicians in the same group practice who have different medical specialties may bill and be paid without regard to their membership in the same group. For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically

necessary and not duplicative, the critical care services may be reported by each regardless of their group practice relationship.

Two or more physicians in the same group practice who have different specialties and who provide critical care to a critically ill or critically injured patient may not in all cases each report the initial critical care code (CPT 99291) on the same date. When the group physicians are providing care that is unique to his/her individual medical specialty and managing at least one of the patient's critical illness(es) or critical injury(ies) then the initial critical care service may be payable to each.

However, if a physician or qualified NPP within a group provides "staff coverage" or "follow-up" for each other after the first hour of critical care services was provided on the same calendar date by the previous group clinician (physician or qualified NPP), the subsequent visits by the "covering" physician or qualified NPP in the group shall be billed using CPT critical care add-on code 99292. The appropriate individual NPI number shall be reported on the claim. The services will be paid at the specific physician fee schedule rate for the individual clinician (physician or qualified NPP) billing the service.

Clinical Examples of Critical Care Services

1. Drs. Smith and Jones, pulmonary specialists, share a group practice. On Tuesday Dr. Smith provides critical care services to Mrs. Benson who is comatose and has been in the intensive care unit for 4 days following a motor vehicle accident. She has multiple organ dysfunction including cerebral hematoma, flail chest and pulmonary contusion. Later on the same calendar date Dr. Jones covers for Dr. Smith and provides critical care services. Medically necessary critical care services provided at the different time periods may be reported by both Drs. Smith and Jones. Dr. Smith would report CPT code 99291 for the initial visit and Dr. Jones, as part of the same group practice would report CPT code 99292 on the same calendar date if the appropriate time requirements are met.

2. Mr. Marks, a 79 year old comes to the emergency room with vague joint pains and lethargy. The ED physician evaluates Mr. Marks and phones his primary care physician to discuss his medical evaluation. His primary care physician visits the ER and admits Mr. Marks to the observation unit for monitoring, and diagnostic and laboratory tests. In observation Mr. Marks has a cardiac arrest. His primary care physician provides 50 minutes of critical care services. Mr. Marks' is admitted to the intensive care unit. On the same calendar day Mr. Marks' condition deteriorates and he requires intermittent critical care services. In this scenario the ED physician should report an emergency department visit and the primary care physician should report both an initial hospital visit and critical care services.

J. Critical Care Services and Other Procedures Provided on the Same Day by the Same Physician as Critical Care Codes 99291 – 99292

The following services when performed on the day a physician bills for critical care are included in the critical care service and should not be reported separately:

- The interpretation of cardiac output measurements (CPT 93561, 93562);
- Chest x-rays, professional component (CPT 71010, 71015, 71020);
- Blood draw for specimen (CPT 36415);
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data-CPT 99090);
- Gastric intubation (CPT 43752, 91105);
- Pulse oximetry (CPT 94760, 94761, 94762);
- Temporary transcutaneous pacing (CPT 92953);
- Ventilator management (CPT 94002 – 94004, 94660, 94662); and
- Vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600).

No other procedure codes are bundled into the critical care services. Therefore, other medically necessary procedure codes may be billed separately.

K. Global Surgery

Critical care services shall not be paid on the same calendar date the physician also reports a procedure code with a global surgical period unless the critical care is billed with CPT modifier -25 to indicate that the critical care is a significant, separately identifiable evaluation and management service that is above and beyond the usual pre and post operative care associated with the procedure that is performed.

Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow directed catheter e.g., Swan-Ganz (CPT code 93503) are not bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing the pre, intra, and post procedure work of these unbundled services, e.g., endotracheal intubation, shall be excluded from the determination of the time spent providing critical care.

This policy applies to any procedure with a 0, 10 or 90 day global period including cardiopulmonary resuscitation (CPT code 92950). CPR has a global period of 0 days and is not bundled into critical care codes. Therefore, critical care may be billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing CPR shall be excluded from the

determination of the time spent providing critical care. In this instance it must be the physician who performs the resuscitation who bills for this service. Members of a code team must not each bill Medicare Part B for this service.

When postoperative critical care services (for procedures with a global surgical period) are provided by a physician other than the surgeon, no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, CPT modifiers "-54" (surgical care only) and "-55"(postoperative management only) must be used by the surgeon and intensivist who are submitting claims. Medical record documentation by the surgeon and the physician who assumes a transfer (e.g., intensivist) is required to support claims for services when CPT modifiers -54 and -55 are used indicating the transfer of care from the surgeon to the intensivist. Critical care services must meet all the conditions previously described in this manual section.

L. Critical Care Services Provided During Preoperative Portion and Postoperative Portion of Global Period of Procedure with 90 Day Global Period in Trauma and Burn Cases

Preoperative

Preoperative critical care may be paid in addition to a global fee if the patient is critically ill and requires the full attention of the physician, and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed. Such patients may meet the definition of being critically ill and criteria for conditions where there is a high probability of imminent or life threatening deterioration in the patient's condition.

Preoperatively, 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 identifying that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed shall be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Postoperative

Postoperatively, in order for critical care 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 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

M. Teaching Physician Criteria

In order for the teaching physician to bill for critical care services the teaching physician must meet the requirements for critical care described in the preceding sections. For CPT codes determined on the basis of time, such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes. (See IOM, Pub 100-04, Chapter12, § 100.1.4)

1. Teaching

Time spent teaching may not be counted towards critical care time. Time spent by the resident, in the absence of the teaching physician, cannot be billed by the teaching physician as critical care or other time-based services. Only time spent by the resident and teaching physician together with the patient or the teaching physician alone with the patient can be counted toward critical care time.

2. Documentation

A combination of the teaching physician's documentation and the resident's documentation may support critical care services. Provided that all requirements for critical care services are met, the teaching physician documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment. However, the teaching physician medical record documentation must provide substantive information including: (1) the time the teaching physician spent providing critical care, (2) that the patient was critically ill during the time the teaching physician saw the patient, (3) what made the patient critically ill, and (4) the nature of the treatment and management provided by the teaching physician. The medical review criteria are the same for the teaching physician as for all physicians. (See the Medicare Claims Processing, Pub. 100-04, Chapter 12, §100.1.1 for teaching physician documentation guidance.)

Unacceptable Example of Documentation:

> "I came and saw (the patient) and agree with (the resident)".

Acceptable Example of Documentation:

> "Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the

resident's documentation and I agree with the resident's assessment and plan of care."

N. Ventilator Management

Medicare recognizes the ventilator codes (CPT codes 94002 - 94004, 94660 and 94662) as physician services payable under the physician fee schedule. Medicare Part B under the physician fee schedule does not pay for ventilator management services in addition to an evaluation and management service (e.g., critical care services, CPT codes 99291 - 99292) on the same day for the patient even when the evaluation and management service is billed with CPT modifier -25.

30.6.13 - Nursing Facility Services

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

The distinction made between the delegation of physician visits and tasks in a skilled nursing facility (SNF) and in a nursing facility (NF) is based on the Medicare Statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs. For further information refer to Medlearn Matters article number SE0418 at www.cms.hhs.gov/medlearn/matters.

The federally mandated visits in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4) and (f)). The principal physician of record must append the modifier "-AI", (Principal Physician of Record), to the initial nursing facility care code. This modifier will identify the physician who oversees the patient's care from other physicians who may be furnishing specialty care. All other physicians or qualified NPPs who perform an initial evaluation in the NF or SNF may bill the initial nursing facility care code. The initial federally mandated visit is defined in S&C-04-08 (see www.cms.hhs.gov/medlearn/matters) as the initial comprehensive visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, a visit must occur no later than 30 days after admission.

Further, per the Long Term Care regulations at 42 CFR 483.40 (c) (4) and (e) (2), in a SNF the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C-04-08 the physician may not delegate the initial federally mandated comprehensive visit in a SNF.

The only exception, as to who performs the initial visit, relates to the NF setting. In the NF setting, a qualified NPP (i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS)), who is not employed by the facility, may perform the initial visit when the State law permits. The evaluation and management (E/M) visit shall be within the State scope of practice and licensure requirements where the E/M visit is

performed and the requirements for physician collaboration and physician supervision shall be met.

Under Medicare Part B payment policy, other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit. A qualified NPP may perform medically necessary E/M visits prior to and after the initial visit if all the requirements for collaboration, general physician supervision, licensure, and billing are met.

The CPT Nursing Facility Services codes shall be used with place of service (POS) 31 (SNF) if the patient is in a Part A SNF stay. They shall be used with POS 32 (nursing facility) if the patient does not have Part A SNF benefits or if the patient is in a NF or in a non-covered SNF stay (e.g., there was no preceding 3-day hospital stay). The CPT Nursing Facility code definition also includes POS 54 (Intermediate Care Facility/Mentally Retarded) and POS 56 (Psychiatric Residential Treatment Center). For further guidance on POS codes and associated CPT codes refer to §30.6.14.

Effective January 1, 2006, the Initial Nursing Facility Care codes 99301– 99303 are deleted.

Beginning January 1, 2006, the new CPT codes, Initial Nursing Facility Care, per day, (99304 – 99306) shall be used to report the initial federally mandated visit. Only a physician may report these codes for an initial federally mandated visit performed in a SNF or NF (with the exception of the qualified NPP in the NF setting who is not employed by the facility and when State law permits, as explained above).

A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.

A physician who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment. An NPP who is employed by the SNF or NF may perform and bill Medicare Part B directly for those services where it is permitted as discussed above. The employer of the PA shall always report the visits performed by the PA. A physician, NP or CNS has the option to bill Medicare directly or to reassign payment for his/her professional service to the facility.

As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial federally mandated visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. A physician or NPP may bill the most appropriate initial

nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

SNF Setting--Place of Service Code 31

Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting--Place of Service Code 32

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial federally mandated visit by the physician or qualified NPP where permitted, payment shall be made for federally mandated visits that 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.

Effective January 1, 2006, the Subsequent Nursing Facility Care, per day, codes 99311–99313 are deleted.

Beginning January 1, 2006, the new CPT codes, Subsequent Nursing Facility Care, per day, (99307 – 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.

Carriers shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service. The Nursing Facility Services codes represent a “per day” service.

The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the

scheduled mandated physician E/M visit occurs). The physician/qualified NPP shall bill only one E/M visit.

Beginning January 1, 2006, the new CPT code, Other Nursing Facility Service (99318), may be used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. For Medicare Part B payment policy, an annual nursing facility assessment visit code may substitute as meeting one of the federally mandated physician visits if the code requirements for CPT code 99318 are fully met and in lieu of reporting a Subsequent Nursing Facility Care, per day, service (codes 99307 – 99310). It shall not be performed in addition to the required number of federally mandated physician visits. The new CPT annual assessment code does not represent a new benefit service for Medicare Part B physician services.

Qualified NPPs, whether employed or not by the SNF, may perform alternating federally mandated physician visits, at the option of the physician, after the initial federally mandated visit by the physician in a SNF.

Qualified NPPs in the NF setting, who are not employed by the NF and who are working in collaboration with a physician, may perform federally mandated physician visits, at the option of the State.

Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes. E/M visits, prior to and after the initial federally mandated physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.

C. Visits by Qualified Nonphysician Practitioners

All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs. General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT

codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

SNF Setting--Place of Service Code 31

Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting--Place of Service Code 32

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

D. Medically Complex Care

Payment is made for E/M visits to patients in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are reasonable and medically necessary and documented in the medical record. Physicians and qualified NPPs shall report initial nursing facility care codes for their first visit with the patient. The principal physician of record must append the modifier "-AI" (Principal Physician of Record), to the initial nursing facility care code when billed to identify the physician who oversees the patient's care from other physicians who may be furnishing specialty care. Follow-up visits shall be billed as subsequent nursing facility care visits.

E. Incident to Services

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" E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B. Thus, visits performed outside the designated "office" area in the SNF/NF would be subject to the coverage and payment rules applicable to the SNF/NF setting and shall not be reported using the CPT codes for office or other outpatient visits or use place of service code 11.

F. Use of the Prolonged Services Codes and Other Time-Related Services

Beginning January 1, 2008, typical/average time units for E/M visits in the SNF/NF settings are reestablished. Medically necessary prolonged services for E/M visits (codes 99356 and 99357) in a SNF or NF may be billed with the Nursing Facility Services in the code ranges (99304 – 99306, 99307 – 99310 and 99318).

Counseling and Coordination of Care Visits

With the reestablishment of typical/average time units, medically necessary E/M visits for counseling and coordination of care, for Nursing Facility Services in the code ranges (99304 – 99306, 99307 – 99310 and 99318) that are time-based services, may be billed with the appropriate prolonged services codes (99356 and 99357).

G. Multiple Visits

The complexity level of an E/M visit and the CPT code billed must be a covered and medically necessary visit for each patient (refer to §§1862 (a)(1)(A) of the Act). Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits. The E/M visit (Nursing Facility Services) represents a "per day" service per patient as defined by the CPT code. The medical record must be personally documented by the physician or qualified NPP who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient.

H. Split/Shared E/M Visit

A split/shared E/M visit cannot be reported in the SNF/NF setting. A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to critical care services or procedures.

I. SNF/NF Discharge Day Management Service

Medicare Part B payment policy requires a face-to-face visit with the patient provided by the physician or the qualified NPP to meet the SNF/NF discharge day management service as defined by the CPT code. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date. The CPT codes 99315 – 99316 shall be reported for this visit. The Discharge Day Management Service may be

reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.

30.6.14 - Home Care and Domiciliary Care Visits (Codes 99324- 99350)

(Rev. 775, Issued: 12-02-05, Effective: 01-01-06, Implementation: 01-03-06)

Physician Visits to Patients Residing in Various Places of Service

The American Medical Association's Current Procedural Terminology (CPT) 2006 new patient codes 99324 – 99328 and established patient codes 99334 - 99337(new codes beginning January 2006), for 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 CPT codes are used to report E/M services in facilities assigned places of service (POS) codes 13 (Assisted Living Facility), 14 (Group Home), 33 (Custodial Care Facility) and 55 (Residential Substance Abuse Facility). Assisted living facilities may also be known as adult living facilities.

Physicians and qualified nonphysician practitioners (NPPs) 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 CPT code range 99324 – 99337 to report the service they provide. The CPT codes 99321 – 99333 for Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services are deleted beginning January, 2006.

Beginning in 2006, reasonable and medically necessary, face-to-face, prolonged services, represented by CPT codes 99354 – 99355, may be reported with the appropriate companion E/M codes when a physician or qualified NPP, provides a prolonged service involving direct (face-to-face) patient contact that is beyond the usual E/M visit service for a Domiciliary, Rest Home (e.g., Boarding Home) or Custodial Care Service. All the requirements for prolonged services at §30.6.15.1 must be met.

The 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 (e.g., private home, apartment, town home) and not residing in any type of congregate/shared facility living arrangement including assisted living facilities and group homes. The Home Services codes apply only to the specific 2-digit POS 12 (Home). Home Services codes may not be used for billing E/M services provided in settings other than in the private residence of an individual as described above.

Beginning in 2006, E/M services provided to patients residing in a Skilled Nursing Facility (SNF) or a Nursing Facility (NF) must be reported using the appropriate CPT level of service code within the range identified for Initial Nursing Facility Care (new CPT codes 99304 – 99306) and Subsequent Nursing Facility Care (new CPT codes 99307 – 99310). Use the CPT code, Other Nursing Facility Services (new CPT code 99318), for an annual nursing facility assessment. Use CPT codes 99315 – 99316 for SNF/NF discharge services. The CPT codes 99301 – 99303 and 99311 – 99313 are

deleted beginning January, 2006. The Home Services codes should not be used for these places of service.

The CPT SNF/NF code definition includes intermediate care facilities (ICFs) and long term care facilities (LTCFs). These codes are limited to the specific 2-digit POS 31 (SNF), 32 (Nursing Facility), 54 (Intermediate Care Facility/Mentally Retarded) and 56 (Psychiatric Residential Treatment Center).

The CPT nursing facility codes should be used with POS 31 (SNF) if the patient is in a Part A SNF stay and POS 32 (nursing facility) if the patient does not have Part A SNF benefits. There is no longer a different payment amount for a Part A or Part B benefit period in these POS settings.

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 With Direct Face-to-Face Patient Contact Service (ZZZ codes)

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

A. Definition

Prolonged physician services (CPT code 99354) in the office or other outpatient setting with direct face-to-face patient contact which require 1 hour beyond the usual service are payable when billed on the same day by the same physician or qualified nonphysician practitioner (NPP) as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion evaluation and management service as noted in the CPT code. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99355.

Prolonged physician services (code 99356) in the inpatient setting, with direct face-to-face patient contact which require 1 hour beyond the usual service are payable when they are billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99357.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.

Code 99355 or 99357 may be used to report each additional 30 minutes beyond the first hour of prolonged services, based on the place of service. These codes may be used to report the final 15 – 30 minutes of prolonged service on a given date, if not otherwise billed. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

B. Required Companion Codes

The companion evaluation and management codes for 99354 are the Office or Other Outpatient visit codes (99201 - 99205, 99212 – 99215), the Domiciliary, Rest Home, or Custodial Care Services codes (99324 – 99328, 99334 – 99337), the Home Services codes (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 evaluation and management codes for 99356 are the Initial Hospital Care codes and Subsequent Hospital Care codes (99221 - 99223, 99231 – 99233); Nursing Facility Services codes (99304 -99318); or

The companion codes for 99357 are 99356 and one of the evaluation and management codes required for 99356 to be used.

Prolonged services codes 99354 – 99357 are not paid unless they are accompanied by the companion codes as indicated.

C. 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/average 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 reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient, or 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.

D. 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 medically necessary evaluation and management service and prolonged services billed. The medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show that the physician or qualified NPP personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. The start and end times of the visit shall be documented in the medical record along with the date of service.

E. Use of the Codes

Prolonged services codes can be billed only if the total duration of the physician or qualified NPP direct face-to-face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code 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 or qualified NPP provided, the physician or qualified NPP may not bill for prolonged services.

F. Threshold Times for Codes 99354 and 99355 (Office or Other Outpatient Setting)

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 evaluation and management visit code 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 one unit of code 99355. One additional unit of code 99355 is billed for each additional increment of 30 minutes extended duration. Contractors use the following threshold times to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings including domiciliary, rest home, or custodial care services and home services codes.

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

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
99324	20	50	95
99325	30	60	105
99326	45	75	120
99327	60	90	135
99328	75	105	150
99334	15	45	90
99335	25	55	100
99336	40	70	115
99337	60	90	135
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 two units of code 99355. For example, to bill code 99354 and two units of code 99355 when billing a code 99205, the threshold time is 150 minutes.

G. Threshold Times for Codes 99356 and 99357

(Inpatient Setting) 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. Contractors do not accept more than one 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. Contractors use the following threshold times to determine if the prolonged services codes 99356 and/or 99357 can be billed with the inpatient setting codes.

Threshold Time for Prolonged Visit Codes 99356 and/or 99357 Billed with Inpatient Setting 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

Add 30 minutes to the threshold time for billing codes 99356 and 99357 to get the threshold time for billing code 99356 and two units of 99357.

H. Prolonged Services Associated With Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)

When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management code is selected based on the typical/average time associated with the code levels. The time approximation must meet

or exceed the specific CPT code billed (determined by the typical/average time associated with the evaluation and management code) and should not be “rounded” to the next higher level.

In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.

I. Examples of Billable Prolonged Services

EXAMPLE 1

A physician performed a visit that met the definition of an office 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 one unit of code 99354.

EXAMPLE 2

A physician performed a visit that met the definition of a domiciliary, rest home care visit code 99327 and the total duration of the direct face-to-face contact (including the visit) was 140 minutes. The physician bills codes 99327, 99354, and one unit of code 99355.

EXAMPLE 3

A physician performed an office visit to an established patient that was predominantly counseling, spending 75 minutes (direct face-to-face) with the patient. The physician should report CPT code 99215 and one unit of code 99354.

J. 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.

EXAMPLE 3

A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354. The physician must bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.

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

(Rev. 1490, Issued: 04-11-08, Effective: 07-01-08, Implementation: 07-07-08)

Contractors may not pay prolonged services codes 99358 and 99359, which do not require any direct patient face-to-face contact (e.g., telephone calls). 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.

30.6.15.4 – Power Mobility Devices (PMDs) (Code G0372)

(Rev. 748, Issued: 11-04-05; Effective/Implementation Dates: 10-25-05)

Section 302(a)(2)(E)(iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) sets forth revised conditions for Medicare payment of Power Mobility Devices (PMDs). This section of the MMA states that payment for motorized or power wheelchairs may not be made unless a physician (as defined in §1861(r)(1) of the Act), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in §1861(aa)(5)) has conducted a face-to-face examination of the beneficiary and written a prescription for the PMD.

Payment for the history and physical examination will be made through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient. Due to the MMA requirement that the physician or treating practitioner create a written prescription and a regulatory requirement that the physician or treating practitioner prepare pertinent parts of the medical record for submission to the durable medical equipment supplier, code G0372 (physician service required to establish and document the need for a power mobility device) has been established to recognize additional

physician services and resources required to establish and document the need for the PMD.

The G code indicates that all of the information necessary to document the PMD prescription is included in the medical record, and the prescription and supporting documentation is delivered to the PMD supplier within 30 days after the face-to-face examination.

Effective October 25, 2005, G0372 will be used to recognize additional physician services and resources required to establish and document the need for the PMD and will be added to the Medicare physician fee schedule.

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 99221-9223, 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 it

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 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 x .17 = .11333 or 11.3%; and

3338 x .17 = .057 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/articulo 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 notificatión, 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 MFSDB 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. 1859; Issued: 11-20-09; Effective Date: For services furnished on or after 01-01-10; Implementation Date: 01-04-10)

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 communicated to the Part B Contractors by means of the HCPCS file released annually. The public can access the base units on the CMS homepage through the anesthesiologist's center. The way in which time units are calculated is described in §50.G. CMS releases the conversion factor annually.

B. Payment at Personally Performed Rate

The Part B Contractor 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 involved in the training of physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. The physician meets the teaching physician criteria in §100.1.4 and the service is furnished on or after January 1, 2010;
- 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

The Part B Contractor determines 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.

For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single resident case that is concurrent to another anesthesia case paid under the medical direction rules or to two concurrent anesthesia cases involving residents.

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

The Part B Contractor 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

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, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place. The A/B MAC does 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

The Part B Contractor pays 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

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; and

GC - these services have been performed by a resident under the direction of a teaching physician.

The GC modifier is reported by the teaching physician to indicate he/she rendered the service in compliance with the teaching physician requirements in §100.1.2. One of the payment modifiers must be used in conjunction with the GC modifier.

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

The Part B Contractor 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 procedure is medically directed. They must also be able to determine the number of anesthesia time units from actual anesthesia time reported on the claim. The Part B Contractor must multiply allowable units by the anesthesia-specific conversion factor used to determine fee schedule payment for the payment area.

L. Anesthesia and Medical/Surgical Service Provided by the Same Physician

Anesthesia services range in complexity. The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia and general anesthesia. Prior to 2006, Medicare did not recognize separate payment if the same physician provided the medical or surgical procedure and the anesthesia needed for the procedure.

Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care. In 2006, the CPT added new codes 99143 to 99150 for moderate or conscious sedation. The moderate (conscious) sedation codes are carrier priced under the Medicare physician fee schedule.

The CPT codes 99143 to 99145 describe moderate sedation provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status. The physician can bill the conscious sedation codes 99143 to 99145 as long as the procedure with it is billed is not listed in Appendix G of CPT. CPT codes 99148 to 99150 describe moderate sedation provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports.

The CPT includes Appendix G, Summary of CPT Codes That Include Moderate (Conscious) Sedation. This appendix lists those procedures for which moderate (conscious) sedation is an inherent part of the procedure itself. CPT coding guidelines instruct practices not to report CPT codes 99143 to 99145 in conjunction with codes listed in Appendix G. The National Correct Coding Initiative has established edits that bundle CPT codes 99143 and 99144 into the procedures listed in Appendix G.

In the unusual event when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting for the procedures listed in Appendix G, the second physician can bill 99148 to 99150. The term, facility, includes those places of service listed in Chapter 23 Addendum -- field 29. However, when these services are performed by the second physician in the nonfacility setting, CPT codes 99148 to 99150 are not to be reported.

If the anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections and a different provider performs the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using CPT code 01991. The service must meet the criteria for monitored anesthesia care. If the anesthesiologist or CRNA provides both the anesthesia service and the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using the conscious sedation code and the injection or block. However, the anesthesia service must meet the

requirements for conscious sedation and if a lower level complexity anesthesia service is provided, then the conscious sedation code should not be reported.

If the physician performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, then the conscious sedation code should not be reported and no payment should be allowed by the carrier. There is no CPT code for the performance of local anesthesia and as payment for this service is considered in the payment for the underlying medical or surgical service.

60 - Payment for Pathology Services

(Rev. 382, Issued: 11-26-04, Effective: 01-01-05, Implementation: 01-03-05)

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

A. General Payment Rule

Payment may be made under the fee schedule for the professional component of physician laboratory or physician pathology services furnished to hospital inpatients or outpatients by hospital physicians or by independent laboratories, if they qualify as the reassignee for the physician service.. Payment may be made under the fee schedule, as noted below, for the technical component (TC) of pathology services furnished by an independent laboratory to hospital inpatients or outpatients. Payment may be made under the fee schedule for the technical component of physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients. The Medicare physician fee schedule identifies those physician laboratory or physician pathology services that have a technical component service.

CMS published a final regulation in 1999 that would no longer allow independent laboratories to bill under the physician fee schedule for the TC of physician pathology services. The implementation of this regulation was delayed by Section 542 of the Benefits and Improvement and Protection Act of 2000 (BIPA). Section 542 allows the Medicare carrier to continue to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital. This provision is applicable to TC services furnished in 2001, 2002, 2003, 2004, 2005 or 2006.

For this provision, a covered hospital is a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and submitted claims for payment for the TC to a carrier. The TC could have been submitted separately or combined with the professional component and reported as a combined service.

The term, fee-for-service Medicare beneficiary, means an individual who:

Is entitled to benefits under Part A or enrolled under Part B of title XVIII or both; and

Is not enrolled in any of the following: A Medicare + Choice plan under Part C of such title; a plan offered by an eligible organization under §1876 of the Social Security Act; a program of all-inclusive care for the elderly under §1894; or a social health maintenance organization demonstration project established under Section 4108 of the Omnibus Budget Reconciliation Act of 1987.

In implementing Section 542, the carriers should consider as independent laboratories those entities that it has previously recognized as independent laboratories.

An independent laboratory that has acquired another independent laboratory that had an arrangement of July 22, 1999, with a covered hospital, can bill the TC of physician pathology services for that hospital's inpatients and outpatients under the physician fee schedule.

An independent laboratory that furnishes the TC of physician pathology services to inpatients or outpatients of a hospital that is not a covered hospital may not bill the carrier for the TC of physician pathology services during the time §542 is in effect.

If the arrangement between the independent laboratory and the covered hospital limited the provision of TC physician pathology services to certain situations or at particular times, then the independent laboratory can bill the carrier only for these limited services.

The carrier shall require independent laboratories that had an arrangement, on or prior to July 22, 1999 with a covered hospital, to bill for the technical component of physician pathology services to provide a copy of this agreement, or other documentation substantiating that an arrangement was in effect between the hospital and the independent laboratory as of this date. The independent laboratory must submit this documentation for each covered hospital that the independent laboratory services.

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:

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, 88361, 88362, 88365, 88380.

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

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, 88112, 88125, 88141, 88160, 88161, 88162, 88172, 88173, 88180, 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 non-hospital) 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:

Are requested by the patient's attending physician;

Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient;

Result in a written narrative report included in the patient's medical record; and

Require the exercise of medical judgment by the consultant physician.

Clinical consultations are professional component services 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 ask 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

Code	Definition
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 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 or 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. 1604, Issued: 09-26-08, Effective: 01-08-08, Implementation: 01-05-09)

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 typically less than the nonfacility fee for services performed in the physician's office.

90.4 - Billing and Payment in a Health Professional Shortage Area (HPSA)

(Rev. 1273; Issued: 06-29-07; Effective/Implementation Dates: 10-01-07)

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;

Providing a link to the CMS Web site to access the HPSA automated ZIP code files;

Providing a direct link to HRSA's HPSA database

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 submitted using the AQ modifier.

90.4.1 – Provider Education

(Rev. 1639, Issued: 11-21-08, Effective: 01-01-09, Implementation: 01-05-09)

ZIP Code files for the automated payment of the HPSA bonus payment will be developed and updated annually. Effective for claims with dates of service on or after January 1, 2009, only services provided in areas that are designated as of December 31 of the prior year are eligible for the HPSA bonus payment. Physicians providing services in areas that were designated as of December 31 of the prior year but not on the automated file may use the AQ modifier. Only services provided in areas that were designated as of December 31 of the prior year but not on the automated file may use the modifier. Services provided in areas that are designated throughout the year will not be eligible for the HPSA bonus payment until the following year, provided they are still designated on December 31. Services provided in areas that are de-designated throughout the year will continue to be eligible for the HPSA bonus through the end of the calendar year.

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 or the HRSA Website for the area where they provide physician services.

90.4.1.1 – Carrier Web Pages

(Rev. 1273; Issued: 06-29-07; Effective/Implementation Dates: 10-01-07)

Carrier Web pages shall direct the physician community to a direct link to the CMS Web site to access the automated HPSA bonus payment files, and a direct link to the HRSA/HPSA designations database.

90.4.2 - HPSA Designations

(Rev. 1639, Issued: 11-21-08, Effective: 01-01-09, Implementation: 01-05-09)

HPSA designations are made by the Health Resources and Services Administration's (HRSA) Division of Shortage Designation (DSD). An automated file of areas eligible for the HPSA bonus payment 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. Physicians may only use the AQ modifier for services furnished in an area that was

designated as of December 31 of the prior year. This information can be downloaded from the HRSA Web site.

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; or are partially within a partial county HPSA, physicians must submit a AQ modifier to receive payment.

To determine whether a modifier is needed, physicians must review the information provided on the CMS Web or the HRSA 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 Web site at www.Census.gov or the Federal Financial Institutions Examination Council (FFIEC) Web site at www.ffiec.gov/geocode/default.htm. Instructions on how to use these Web sites can be found on the CMS Web site at http://new.cms.hhs.gov/HPSAPSAPhysicianBonuses. Neither CMS nor the Medicare carriers can provide information on the functionality of these Web sites.

90.4.3 - Claims Coding Requirements

(Rev. 608, Issued: 07-22-05; Effective: 01-01-06; Implementation: 01-03-06)

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.

Effective for claims with dates of service on or after January 1, 2006, the QB and QU modifiers will no longer be accepted. Claims with prior dates of service must still be

submitted with those modifiers. The AQ modifier, Physician providing a service in a Health Professional Shortage Area (HPSA), will replace the QB and QU modifiers and will be effective for claims with dates of service on or after January 1, 2006.

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

The submission of the QB or QU modifier, or the AQ modifier for claims with dates of service on or after January 1, 2006, 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; and.
- 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. 2040, Issued: 08-27-10, Effective: 01-01-11 and 04-04-11, Implementation: 01-03-11 for the claim identification of the incentive and 04-04-11 for full implementation)

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

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

- Establish a quarterly schedule for issuing incentive payments. These payments are taxable and must be reported to the IRS; and

- Prepare a special incentive remittance 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. Claims should be identified as HPSA physician, Scarcity, HSIP and/or PCIP in the summary. 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. 906, Issued: 04-14-06; Effective: 07-01-06; Implementation: 07-03-06)

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. Should carriers receive notification from physicians that they have chosen to forego the bonus payments, the carriers shall make no bonus payments to that physician for any service.

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. ACTION: Effective for claims received prior to October 1, 2005, 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. If the technical component is the only component of the service that was performed in the bonus area, there wouldn't be a qualifying service. Effective for claims received on or after October 1, 2005, carriers shall accept claims with services with a PC/TC indicator of 1 that are eligible for the HPSA or PSA bonus. They shall pay the bonus only on the professional component of the service.

PC/TC Indicator	Bonus Payment Policy
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: Effective for claims received prior to July 1, 2006, carriers return the service as unprocessable. They instruct the provider to re-bill the service as separate professional and technical component procedure codes. Effective for claims received on or after July 1, 2006, except for 93015, carriers shall accept claims with services with a PC/TC indicator of 4 that are eligible for the HPSA or PSA bonus. They shall pay the bonus only on the associated professional component of the service. Since 93015 has two associated professional components, carriers will not be able to make a determination as to which would be the correct component to use to calculate the bonuses. Therefore, carriers shall continue to treat 93015 as unprocessable.
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 bonus payment will be paid for these codes.

B. Anesthesia Codes (CPT Codes 00100 Through 01999) That Do Not Appear on the MFSDB

Anesthesia codes (CPT codes 00100 through 01999) do not appear on the MFSDB. 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, or the AQ modifier for claims with dates of service on or after January 1, 2006, when required per §90.4.3 or the AR modifier as required per §90.5.3.

C. Mental Health Services

Physicians' professional 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. 280, Issued 08-13-04, Effective/Implementation: October 1, 2004 for the analysis and design phases for the MCS Maintainer and Contractors

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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. 608, Issued: 07-22-05; Effective: 01-01-06; Implementation: 01-03-06)

On a post-payment basis, services submitted with the QB or QU modifier, or the AQ modifier for claims with dates of service on or after January 1, 2006, will be subject to validation.

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. 608, Issued: 07-22-05; Effective: 01-01-06; Implementation: 01-03-06)

If a CAH electing the Optional Method (Method II) is located within a mental health HPSA, the psychiatrists providing (outpatient) professional services in the CAH are eligible for the Mental Health and Primary Care HPSA bonus payments. When billing for this service, the CAH must bill using Revenue code 961 plus the applicable HCPCS. This Mental Health HPSA bonus will be paid to the CAH on a quarterly basis by the FI. If an area is designated as both a mental health HPSA and a primary medical HPSA, only one 10% bonus will be paid for the service.

Refer to §250.2 in the Claims Processing Manual, Chapter 4 for additional information.

90.4.10 – Administrative and Judicial Review

(Rev. 280, Issued 08-13-04, Effective/Implementation: October 1, 2004 for the analysis and design phases for the MCS Maintainer and Contractors

January 1, 2005 for the coding, testing, and implementation phases for the MCS Maintainer and Contractors

January 1, 2005 for all phases for the VIPS Maintainers and Contractors)

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.

90.4.11 - Health Professional Shortage Areas (HPSA) Surgical Incentive Payment Program (HSIP) for Surgical Services Rendered in HPSAs

(Rev. 2040, Issued: 08-27-10, Effective: 01-01-11 and 04-04-11, Implementation: 01-03-11 for the claim identification of the incentive and 04-04-11 for full implementation)

Section 5501(b) of the Affordable Care Act revises Section 1833(m) of the Act and authorizes a 10 percent incentive payment for 10 - and 90 - day global surgical procedures furnished by 02 – general surgeons in Health Professional Shortage Areas (HPSAs).

90.4.11.1 - Overview of the HSIP

(Rev. 2040, Issued: 08-27-10, Effective: 01-01-11 and 04-04-11, Implementation: 01-03-11 for the claim identification of the incentive and 04-04-11 for full implementation)

The incentive payment applies to major surgical procedures, that are defined as 10 - and 90 - day global procedures under the Physician Fee Schedule (PFS) and furnished on or after January 1, 2011, and before January 1, 2016, by an 02-general surgeon in an area designated under Section 332(a)(1)(A) of the Public Health Service Act as a HPSA.

To be consistent with the Medicare HPSA physician bonus program (Pub. 100-04, Chapter 12, §90.4), HSIP payments are calculated by Medicare contractors on a quarterly basis, on behalf of the qualifying general surgeon, for the qualifying surgical procedures. The surgeons' professional services are paid under the PFS based on a claim for professional services.

90.4.11.2 - HPSA Identification

(Rev. 2040, Issued: 08-27-10, Effective: 01-01-11 and 04-04-11, Implementation: 01-03-11 for the claim identification of the incentive and 04-04-11 for full implementation)

For HSIP payments to be applicable, the 10 - or 90 - day global surgical procedure must be furnished in an area designated by the Secretary as of December 31 of the prior year as a HPSA.

Each year, a list of ZIP codes eligible for automatic payment of the HSIP incentive payment (and the Medicare HPSA physician bonus program) is published. This list is utilized for automatic payments of the incentive for eligible services furnished by general surgeons. Contractors will use the existing HPSA modifier -AQ ,along with the physician specialty (02), to identify circumstances when general surgeons furnish major surgical procedures in areas that are designated as HPSAs as of December 31 of the prior year, but that are not on the list of ZIP codes eligible for automatic payment. Modifier -AQ should be appended to the major surgical procedure on claims submitted for payment under these circumstances.

90.4.11.3 - Coordination with Other Payments

(Rev. 2040, Issued: 08-27-10, Effective: 01-01-11 and 04-04-11, Implementation: 01-03-11 for the claim identification of the incentive and 04-04-11 for full implementation)

Section 5501(b)(4) of the Affordable Care Act provides payment under the HSIP as an additional payment amount for specified surgical services without regard to any additional payment for the service under section 1833(m) of the Act. Therefore, a general surgeon may receive both a HPSA physician bonus payment under the established program, and an HSIP payment under the new program beginning in CY 2011.

90.4.11.4 - General Surgeon and Surgical Procedure Identification for Professional Services Paid Under the Physician Fee Schedule (PFS)

(Rev. 2040, Issued: 08-27-10, Effective: 01-01-11 and 04-04-11, Implementation: 01-03-11 for the claim identification of the incentive and 04-04-11 for full implementation)

Qualifying general surgeons are identified on a claim for a 10 - or 90 - day global surgical procedure based on the primary specialty of the rendering physician, identified by his or her National Provider Identifier (NPI), of 02 – general surgery. If the claim is submitted by a physician group practice, the rendering physician's NPI must be included on the line-item for the qualifying surgical procedure in order for a determination to be made regarding whether or not the procedure is eligible for payment under the HSIP.

Eligible surgical procedures are those procedures for which a 10 - or 90 - day global period is used for payment under the PFS. The specific HCPCS procedure codes eligible for the HSIP are identified in column U (global period) of the Physician Fee Schedule Relative Value Update (RVU) file located at: http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=4, with a global period designation of 10 - or 90 - days.

90.4.11.5 - Claims Processing and Payment

(Rev. 2040, Issued: 08-27-10, Effective: 01-01-11 and 04-04-11, Implementation: 01-03-11 for the claim identification of the incentive and 04-04-11 for full implementation)

A. General Overview

The HPSA physician bonus program guidelines are contained in Pub. 100-04, Chapter 12, §90.4. Refer to that section for payment and claims processing guidance for the HPSA physician bonus program that was established in 2005. The following guidelines pertain only to the additional 10 percent incentive payment for 10 - or 90 - day global surgical procedures furnished by 02 – general surgeons in HPSAs from January 1, 2011 through December 31, 2015.

Contractors shall identify eligible surgical procedures with a 10 - or 90 - day global period rendered in an eligible primary care HPSA zip code area based on the HPSA physician bonus ZIP code file for the appropriate date of service. The HPSAs eligible for automatic payment may be found on the CMS Web site at: http://www.cms.gov/HPSAPSAPhysicianBonuses/01_overview.asp.

Contractors must also inform eligible practitioners about the use of modifier -AQ on claims for 10 - or 90 - day global surgical procedures that were furnished in HPSAs approved by December 31 of the preceding calendar year, but that are not recognized for automatic payment. The modifier must be appended to the surgical procedure for the service to be eligible for the 10 percent additional HSIP payment.

B. Method of Payment

- Calculate and pay general surgeons an additional 10 percent incentive payment;
- Calculate the payment based on the amount actually paid for the service, not the Medicare approved amount;
- Combine the HSIP incentive payments, when appropriate, with other incentive payments, including the HPSA physician bonus payment;
- Accept and pay the incentive payment for 10 - and 90 - day global period surgical procedures furnished by general surgeons (02) and submitted with the modifier -AQ;
- Provide a special remittance form that is forwarded with the incentive payment so that physicians and nonphysician practitioners can identify which type of incentive payment (HPSA, HSIP, and/or PCIP) was paid for which services;
- Use the PLB03 adjustment reason code LE;

- Add the following message to the incentive checks: This check is for the HPSA, HSIP and/or PCIP. See special remittance for details; and

- Inform practitioners to contact their contractor with any questions regarding HSIP payments.

C. Changes for Contractor Systems

The Medicare Carrier System, (MCS), Common Working File (CWF,) and National Claims History (NCH) shall be modified to accept a new incentive HPSA/PSA/HSIP/PCIP payment indicator on the claim line.

Once the type of incentive has been identified by the shared systems, the shared system shall transmit the HPSA/PSA/HSIP/PCIP indicator to CWF and modify their systems to set the indicator on the claim line as follows:

1 = HPSA;
2 = PSA;
3 = HPSA and PSA;
4 = HSIP;
5 = HPSA and HSIP;
6 = PCIP;
7 = HPSA and PCIP; and
Space = Not Applicable.

The contractor shared system shall send the HIGLAS 810 invoice for incentive payment invoices, including the new HSIP payment. The contractor shall also combine the practitioner's HPSA physician bonus, Physician Scarcity (PSA) bonus (if it should become available at a later date), HSIP payment, and/or PCIP payment invoice per practitioner. The contractor shall receive the HIGLAS 835 payment file from HIGLAS showing a single incentive payment per practitioner.

90.5 – Billing and Payment in a Physician Scarcity Area (PSA)
(Rev. 1434; Issued: 02-05-08; Effective: 01-01-08; Implementation: 01-07-08)

Section 413a of the MMA requires that a 5 percent bonus payment be established for physicians in designated physician scarcity areas for dates of service January 1, 2005, through December 31, 2007. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 amended §1833(u)(1) of the Social Security Act and has extended payment of that bonus through June 30, 2008. Physician scarcity designations will be based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in every county. In addition, based on rural census tracts of metropolitan statistical areas identified through the latest modification of the Goldsmith Modification (i.e., Rural-Urban Commuting Area Codes), additional physician scarcity areas will be identified based on the lowest primary care and specialty

care ratios of Medicare beneficiaries to active physicians in each identified rural census area.

90.5.1 – Provider Education

(Rev. 280, Issued 08-13-04, Effective/Implementation: October 1, 2004 for the analysis and design phases for the MCS Maintainer and Contractors
January 1, 2005 for the coding, testing, and implementation phases for the MCS Maintainer and Contractors
January 1, 2005 for all phases for the VIPS Maintainers and Contractors)

Upon publication of the final rule of the 2005 Medicare Physician Fee Schedule, CMS will post on its Web site zip codes that are eligible for automatic payment of the physician scarcity bonus payment.

90.5.2 – Identifying Physician Scarcity Area Locations

(Rev. 1434; Issued: 02-05-08; Effective: 01-01-08; Implementation: 01-07-08)

The CMS shall provide to the standard systems and carriers a file of zip codes for the automated payment of the primary care and specialty physician scarcity bonus. The file will be effective for claims with dates of service on or after January 1, 2005, through December 31, 2007. Carriers and shared systems will be notified by e-mail of the name of the file and when it will be available for downloading.

The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 amended §1833(u)(1) of the Social Security Act and has extended payment of the Physician Scarcity Area bonus through June 30, 2008, using the same file used for prior years.

90.5.3 – Claims Coding Requirements

(Rev. 280, Issued 08-13-04, Effective/Implementation: October 1, 2004 for the analysis and design phases for the MCS Maintainer and Contractors

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Medicare will automatically pay the physician scarcity bonus on a quarterly basis for services provided in zip code areas that fully fall within a county designated as a PSA, partially fall within a county designated as a PSA area and are considered to be dominant for that county based on a determination by the United States Postal Service (USPS), or fall within a rural census tract of a metropolitan statistical area identified through the latest modification of the Goldsmith Modification that is determined to be a PSA.

In some cases, a service may be provided in a county that is considered to be a PSA, but the zip code is not considered to be dominant for that area. The bonus payment cannot

automatically be made. In order to receive the bonus for those areas, physicians must include the following modifier on the claim:

AR - Physician providing service in a Physician Scarcity Area.

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.

90.5.4 - Payment

(Rev. 280, Issued 08-13-04, Effective/Implementation: October 1, 2004 for the analysis and design phases for the MCS Maintainer and Contractors

January 1, 2005 for the coding, testing, and implementation phases for the MCS Maintainer and Contractors

January 1, 2005 for all phases for the VIPS Maintainers and Contractors)

Section 413a of the MMA adds subsection (u)(6) to Section 1833 of the Social Security Act. For the payment of the physician scarcity bonus, this section defines physicians as doctors of medicine or osteopathy described per Section 1861(r)(1). Therefore, dentists, chiropractors, podiatrists, and optometrists are not eligible for the physician scarcity bonus as either primary care or specialty physicians

Only the provider specialty designations of General Practice - 01, Family Practice - 08, Internal Medicine - 11, and Obstetrics/Gynecology – 16, will be paid the bonus for the zip codes designated as primary care PSAs. All other physician provider specialties will be eligible for the specialty physician scarcity bonus for the zip codes designated as specialty PSAs.

The bonus is to be paid based on date of service. Accommodations must be made in payment systems to maintain an active file for a current period as well as an active file for a previous period so that the bonus can be paid based on date of service. Also, the carriers and standard systems maintainers shall program systems to be able to maintain files for the periods prior to the two active periods as an archive for reference purposes.

90.5.5 – Services Eligible for the Physician Scarcity Bonus

(Rev. 280, Issued 08-13-04, Effective/Implementation: October 1, 2004 for the analysis and design phases for the MCS Maintainer and Contractors

January 1, 2005 for the coding, testing, and implementation phases for the MCS Maintainer and Contractors

January 1, 2005 for all phases for the VIPS Maintainers and Contractors)

Eligible physician services for the physician scarcity bonus are identified in the same manner that they are currently identified for the HPSA bonus payment per Pub. 100-4, Chapter 12, §90.4.5A and B. A quarterly 5 percent bonus payment is made to the physician based on the amount actually paid, not the Medicare approved amount of the service.

90.5.5.1 - Remittance Messages

(Rev. 280, Issued 08-13-04, Effective/Implementation: October 1, 2004 for the analysis and design phases for the MCS Maintainer and Contractors

January 1, 2005 for the coding, testing, and implementation phases for the MCS Maintainer and Contractors

January 1, 2005 for all phases for the VIPS Maintainers and Contractors)

See §90.4.6 for applicable remittance messages when submitted services are not eligible for a HPSA and/or physician scarcity bonus payment.

90.5.6 – Post-payment Review

(Rev. 280, Issued 08-13-04, Effective/Implementation: October 1, 2004 for the analysis and design phases for the MCS Maintainer and Contractors

January 1, 2005 for the coding, testing, and implementation phases for the MCS Maintainer and Contractors

January 1, 2005 for all phases for the VIPS Maintainers and Contractors)

On a post-pay basis, services submitted with the AR modifier will be subject to validation.

90.5.7 - Administrative and Judicial Review

(Rev. 280, Issued 08-13-04, Effective/Implementation: October 1, 2004 for the analysis and design phases for the MCS Maintainer and Contractors

January 1, 2005 for the coding, testing, and implementation phases for the MCS Maintainer and Contractors

January 1, 2005 for all phases for the VIPS Maintainers and Contractors)

Per Section 413(a) 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.

90.6 - The Indian Health Service (IHS) Provider Payment to Non-IHS Physicians for Teleradiology Interpretations

(Rev. 1643, Issued: 12-05-08, Effective: 01-01-07, Implementation: 03-09-09)

The IHS providers may choose to purchase or otherwise contract with non-IHS physicians or practitioners for teleradiology interpretations services. These services may be paid using either contractual reassignment or purchased test methodologies. See Chapter 19, Section 120 of this Manual for further information.

90.7 - Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (including Physician Practices and Clinics): 3-Day Payment Window

(Rev. 2373, Issued: 12-21-11, Effective: 01-01-12, Implementation: 01-03-12)

In accordance with section 102(a)(1) of the PACMBPRA, for outpatient services furnished on or after June 25, 2010, the technical portion of all nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and thus, must be included on the bill for the inpatient stay. Also, the technical portion of outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and the third calendar days (1 calendar day for a nonsubsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless the nondiagnostic services are unrelated to the inpatient hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's inpatient admission). In such cases, the unrelated outpatient hospital nondiagnostic services are covered by Medicare Part B, and the hospital or wholly owned or wholly operated physician practice shall include the technical portion of the services in their billing. PACMBPRA did not change the requirement that the technical portion of all diagnostic services provided by the hospital (or entity wholly owned or wholly operated by the hospital) occurring on the date of an inpatient admission, or during the 3 calendar days (or 1 calendar day) immediately preceding the date of an inpatient admission must be billed with the inpatient admission.

Implementation of the 3-day Payment Window Policy in Wholly Owned or Operated Entities

Wholly owned or wholly operated entities are subject to the 3-day (or 1-day) payment window policy when they furnish preadmission diagnostic services to a patient, who is later admitted as an inpatient on the same day or within the preceding 3 calendar days

(preceding1 calendar day), or when they furnish preadmission nondiagnostic services to a patient, who is later admitted as an inpatient on the same day or within the preceding 3 calendar days (preceding 1 calendar day) for related medical care. Only unrelated nondiagnostic preadmission services are not subject to the payment window policy, where unrelated preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's inpatient admission and are furnished on the 1st, 2nd, or 3rd calendar day immediately preceding the date of the inpatient admission. (Note: nondiagnostic services furnished by a wholly owned or wholly operated physician practice on the date of a beneficiary's inpatient admission to the hospital are always deemed to be related to the admission and their technical portion must be included on the bill for the inpatient admission.) When an entity that is wholly owned or wholly operated by a hospital furnishes a service subject to the 3-day window policy, Medicare will pay the professional component of services with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split. Once the entity has received confirmation of a beneficiary's inpatient admission from the admitting hospital, they shall, for services furnished during the three-day window, append a CMS payment modifier to all claim lines for diagnostic services and for those nondiagnostic services that have been identified as related to the inpatient stay. Physician nondiagnostic services that are unrelated to the hospital admission are not subject to the payment window and shall be billed without the payment modifier.

Definition of Wholly Owned or Wholly Operated Entities

Wholly owned or wholly operated entities are defined in 42 CFR §412.2; "An entity is wholly owned by the hospital if the hospital is the sole owner of the entity." And, "an entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity."

90.7.1 - Payment Methodology: 3-Day Payment Window in Wholly Owned or Wholly Operated Entities (including Physician Practices and Clinics)

(Rev. 2373, Issued: 12-21-11, Effective: 01-01-12, Implementation: 01-03-12)

CMS has established HCPCS payment modifier PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated physician office to a patient who is admitted as an inpatient within 3 days), and requires that the modifier be appended to the physician preadmission diagnostic and admission-related nondiagnostic services, reported with HCPCS/CPT codes, which are subject to the 3-day payment window policy. The wholly owned or wholly operated physician's office will need to manage their billing processes to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred. The hospital is responsible for notifying the practice of an inpatient admissions for a patient who received services in a wholly owned or wholly operated physician office within the 3-day (or, when appropriate,1-day) payment window prior to the inpatient stay. The modifier is effective for claims with

dates of service on or after January 1, 2012. Wholly owned or wholly operated per their readiness to do so. Entities have the discretion to apply these policies for claims with dates of service on and after January 1, 2012, but shall comply with these polices no later than July 1. 2012.

When the modifier is present on claims for service CMS shall pay

- only the Professional Component (PC) for CPT/HCPCS codes with a Technical Component (TC)/PC split that are provided in the 3-day (or, in the case of non-IPPS hospitals, 1-day) payment window, and

- The facility rate for codes without a TC/PC split.

Global Surgical Services and the 3-day Payment Window Policy

We note that the time frames associated with 10 and 90 day global surgical packages could overlap with the 3-day (or 1-day) payment window policy. The 3-day payment window makes no change in billing surgical services according to global surgical rules, and pre- and post-operative services continue to be included in the payment for the surgery. However, there may be times when the surgery itself is subject to the three-day window policy, as would occur if the surgery were performed within the three-day window. For example, a patient could have a minor surgery in a wholly owned or wholly operated physician office and then, due to a complication, be admitted to the hospital as an inpatient. In such cases the modifier shall be appended to the appropriate surgical HCPCS/CPT code.

100 - Teaching Physician Services

(Rev. 811, Issued: 01-13-06, Effective: 01-01-06, Implementation: 02-13-06)

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. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.

Student - An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student.

See §100.1.1B for a discussion concerning E/M service documentation performed by students.

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.

Critical or Key Portion - That part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). For purposes of this section, these terms are interchangeable.

Documentation - Notes recorded in the patient's medical records by a resident, and/or teaching physician or others as outlined in the specific situations below regarding the service furnished. Documentation may be dictated and typed or hand-written, or computer-generated and typed or handwritten. Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172 (b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.

In the context of an electronic medical record, the term 'macro' means a command in a computer or dictation application that automatically generates predetermined text that is not edited by the user.

When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician’s macro, either the resident or the teaching physician must provide customized information that is sufficient to support a medical necessity determination. The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros only.

Physically Present - The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

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

(Rev. 811, Issued: 01-13-06, Effective: 01-01-06, Implementation: 02-13-06)

Pursuant to 42 CFR 415.170, services furnished in teaching settings are paid under the physician fee schedule if the services are:

- Personally furnished by a physician who is not a resident;
- Furnished by a resident where a teaching physician was physically present during the critical or key portions of the service; or
- Certain E/M services furnished by a resident under the conditions contained in §100.01.C.

In all situations, the services of the resident are payable through either the direct GME payment or reasonable cost payments made by the FI.

100.1.1 - Evaluation and Management (E/M) Services

(Rev. 2303, Issued: 09-14-11, Effective: 06-01-11, Implementation: 07-26-11)

A. General Documentation Instructions and Common Scenarios

Evaluation and Management (E/M) Services -- For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT) and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician.

Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

Following are four common scenarios for teaching physicians providing E/M services:

Scenario 1:

The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.

In the absence of a note by a resident, the teaching physician must document as he/she would document an E/M service in a nonteaching setting.

Where a resident has written notes, the teaching physician's note may reference the resident's note. The teaching physician must document that he/she performed the critical or key portion(s) of the service, and that he/she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 2:

The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he/she was present during the performance of the critical or key portion(s) of the service and that he/she was directly involved in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity and the level of the service billed by the teaching physician.

Scenario 3:

The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he/she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 4:

When a medical resident admits a patient to a hospital late at night and the teaching physician does not see the patient until later, including the next calendar day:

- The teaching physician must document that he/she personally saw the patient and participated in the management of the patient. The teaching physician may reference the resident's note in lieu of re-documenting the history of present illness, exam, medical decision-making, review of systems and/or past family/social history provided that the patient's condition has not changed, and the teaching physician agrees with the resident's note.

- The teaching physician's note must reflect changes in the patient's condition and clinical course that require that the resident's note be amended with further information to address the patient's condition and course at the time the patient is seen personally by the teaching physician.

- The teaching physician's bill must reflect the date of service he/she saw the patient and his/her personal work of obtaining a history, performing a physical, and participating in medical decision-making regardless of whether the combination of the teaching physician's and resident's documentation satisfies criteria for a higher level of service. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Following are examples of minimally acceptable documentation for each of these scenarios:

Scenario 1:

Admitting Note: "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

Follow-up Visit: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."

Follow-up Visit: "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

(**NOTE:** In this scenario if there are no resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)

Scenario 2:

Initial or Follow-up Visit: "I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."

Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan."

Scenarios 3 and 4:

Initial Visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

Follow-up Visit: "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."

Follow-up Visit: "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

Following are examples of unacceptable documentation:

"Agree with above.", followed by legible countersignature or identity;

"Rounded, Reviewed, Agree.", followed by legible countersignature or identity;

"Discussed with resident. Agree.", followed by legible countersignature or identity;

"Seen and agree.", followed by legible countersignature or identity;

"Patient seen and evaluated.", followed by legible countersignature or identity; and

A legible countersignature or identity alone.

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

B. E/M Service Documentation Provided By Students

Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to

documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service.

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

Teaching physicians providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

Effective January 1, 2005, the following code is included under the primary care exception: HCPCS code G0402 (Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 12 months of Medicare enrollment).

Effective January 1, 2011, the following codes are included under the primary care exception: HCPCS codes G0438 (Annual wellness visit, including personal preventive plan service, first visit) and G0439 (Annual wellness visit, including personal preventive plan service, subsequent visit).

If a service other than those listed above needs to be furnished, then the general teaching physician policy set forth in §100.1 applies. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.

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 at 42 CFR 413.78(e)(3)(ii).

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a

GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.79(a)(6).

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. Teaching physicians may include residents with less than 6 months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical or key portions of services furnished by the residents with less than 6 months in a GME approved residency program. That is, the primary care exception does not apply in the case of residents with less than 6 months in a GME approved residency program.

Teaching physicians submitting claims under this exception must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident;
- Have the primary medical responsibility for patients cared for by the residents;
- Ensure that the care provided was reasonable and necessary;
- Review the care provided by the resident during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies); and
- Document the extent of his/her own participation in the review and direction of the services furnished to each patient.

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:

- 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.

Residency programs most likely qualifying for this 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. 2303, Issued: 09-14-11, Effective: 06-01-11, Implementation: 07-26-11)

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 critical or key portions of the procedure. The teaching surgeon determines which postoperative visits are considered key or critical and require his or her presence. If the postoperative period extends beyond the patient's discharge and the teaching surgeon is not providing the patient's follow-up care, then instructions on billing for less than the global package in §40 apply. During non-critical or non-key portions of the surgery, if the teaching surgeon is not physically present, he/she must be immediately available to return to the procedure, i.e., he/she cannot be performing another procedure. If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

1. Single Surgery

When the teaching surgeon is present for the entire surgery, 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 Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or 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 in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he/she must

arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. 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 patient 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

Medicare pays at the regular fee schedule level if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching physician must document in the medical records that he/she was present during all critical (or key) portions of the procedure. The teaching physician's physical presence during <u>only</u> the preoperative or postoperative visits with the beneficiary is not sufficient to receive Medicare payment. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a nonphysician anesthetist and the service is furnished prior to January 1, 2010, Medicare pays for the anesthesiologist's services as medical direction.

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

For anesthesia services furnished on or after January 1, 2010, payment may be made under the Medicare physician fee schedule at the regular fee schedule level if the teaching anesthesiologist is involved in the training of a resident in a single anesthesia case, two concurrent anesthesia cases involving residents, or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. To qualify for payment, the teaching anesthesiologist, or different anesthesiologists in the same anesthesia group, must be present during all critical or key portions of the anesthesia service or procedure involved. The teaching anesthesiologist (or another anesthesiologist with whom the teaching physician has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure. The documentation in the patient's medical records must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist as necessary.

If different teaching anesthesiologists are present with the resident during the key or critical periods of the resident case, the NPI of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the claim form.

The teaching anesthesiologist should use the "AA" modifier and the "GC" certification modifier to report such cases. See §50 B. and §0 K.

5. Endoscopy Procedures

To bill Medicare for endoscopic procedures (excluding endoscopic surgery that follows the surgery policy in subsection A, above), the teaching physician must be present during the entire viewing. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

6. Interpretation of Diagnostic Radiology and Other Diagnostic Tests

Medicare pays for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by or reviewed with a teaching physician. If the teaching physician's signature is the only signature on the interpretation, Medicare assumes that he/she is indicating that he/she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he/she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings. Medicare does not pay for an interpretation if the teaching physician only countersigns the resident's interpretation.

100.1.3 - Psychiatry

(Rev. 811, Issued: 01-13-06, Effective: 01-01-06, Implementation: 02-13-06)

The general teaching physician policy set forth in §100.1 applies to psychiatric services. For certain psychiatric services, 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. 811, Issued: 01-13-06, Effective: 01-01-06, Implementation: 02-13-06)

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. Do not add time spent by the

resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary. Examples of codes falling into this category include:

- Individual medical psychotherapy (HCPCS codes 90804 - 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 99358-99359); 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. 1458, Issued: 02-22-08, Effective: 03-24-08, Implementation: 03-24-08)

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.

In the case of end stage renal related visits furnished under the monthly capitation payment method (MCP), the physician presence policy as discussed in §100.1 applies. Patient visits furnished by residents may be counted toward the MCP visits if the teaching MCP physician is physically present during the visit. The teaching physician may utilize the resident's notes, however the teaching physician must document his or her physical presence during the visit(s) furnished by the resident and that he or she reviewed the resident's notes. The teaching physician could document these criteria as part of an extensive once a month MCP note.

100.1.7 - Assistants at Surgery in Teaching Hospitals

(Rev. 811, Issued: 01-13-06, Effective: 01-01-06, Implementation: 02-13-06)

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.

Contact those affected by these instructions to learn the circumstances in individual teaching 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. (Note that a nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under State law can also serve as an assistant at surgery). 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 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. 2303, Issued: 09-14-11, Effective: 06-01-11, Implementation: 07-26-11)

A. B/MAC and Legacy 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 B/MACS and legacy carriers, the shared system suspends claims submitted by a teaching physician, for review.

B. Billing Modifiers

Effective January 1, 1997, services furnished by teaching physicians involving a resident in the care of their patients must be identified as such on the claim. To be payable, claims for services furnished by teaching physicians involving a resident must comply with the requirements in sections 100.1 through 100.1.6 of this chapter, as applicable. Claims for services meeting these requirements must show either the GC or GE modifier as appropriate and described below.

1. Teaching Physician Services that Meet the Requirement for Presence During the Key/Critical Portion of the Service

Claims for teaching physician services in compliance with the requirements outlined in sections 100.1 -100.1.6 of this chapter must include a GC modifier for each service, unless the service is furnished under the primary care center exception described in section 100.1.1C (refer to number 2, below). When a physician (or other appropriate billing provider) places the GC modifier on the claim, he/she is certifying that the teaching physician has complied with the requirements in sections 100.1 through 100.1.6.

2. Teaching Physician Services Under the Exception for E/M Services Furnished in Primary Care Centers

Teaching physicians who meet the requirements in section 100.1.1C of this chapter must provide their contractor with an attestation that they meet the requirements. Claims for services furnished by teaching physicians under the primary care center exception must include the GE modifier on the claim for each service furnished under the primary care center exception.

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 Treatment Limitation

(Rev. 1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)

In general, PAs are paid for covered services at 85 percent of the Medicare Physician Fee Schedule. The carrier must apply the outpatient mental health treatment limitation (the limitation) to all covered mental health therapeutic services furnished by PAs.

Refer to §210 below for a complete discussion of the 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. 1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)

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. Outpatient Mental Health Treatment Limitation

The carrier must apply the outpatient mental health treatment limitation (the limitation) to all covered mental health therapeutic services furnished by NPs and CNSs.

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

120.1 - Direct Billing and Payment for Nonphysician Practitioner Services Furnished to Hospital Inpatients and Outpatients

(Rev. 1168, Issued: 01-26-07, Effective: 04-26-07, Implementation: 04-26-07)

Prior to January 1, 1998, direct billing and payment for nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) services to hospital inpatients and outpatients was available only in limited circumstances, as follows:

- Payment for the professional services of NPs and CNSs to outpatients of a hospital located in an urban area was made to the NP's or CNS's employer;

- Payment for the professional services of NPs and CNSs to outpatients of a hospital located in a rural area was made either directly to the NP or CNS or to the NP's or CNSs' employer; and

- Payment to the employer of a PA for the professional services of a PA to outpatients of a hospital located in rural and urban areas and in designated health professional shortage areas (HPSAs).

Even though payment could be made for PA professional services to hospital outpatients, payment for PA services is never made directly to the PA. Rather, payment for PA services must be made to the PA's employer. Also, no separate payment was made for the professional services of NPs, CNSs, and PAs furnished to hospital inpatients because these services to hospital inpatients were bundled into the payment that hospitals received for "hospital services" and billed under the hospital's cost report.

Effective on January 1, 1998 and after, restrictions were removed on the type of areas and settings in which the professional services of NPs, CNSs, and PAs are paid under Medicare. Additionally, payment for the professional services of NPs, CNSs and PAs is

unbundled when furnished to both hospital inpatients and outpatients. (However, hospitals are required to bill their fiscal intermediary for the facility fee associated with the provision of these nonphysician practitioner's professional services in the hospital setting.)

Accordingly, direct billing and payment for the professional services of NPs and CNSs furnished to hospital patients (inpatients and outpatients) must be made to the NP or the CNS. However, if NPs or CNSs reassign payment to the hospital for their professional services to hospital patients, payment must be made to the hospital for these services at 85% of the physician fee schedule. Payment for NP and CNS services is made only on an assignment-related basis.

The employer or contractor of a PA must bill the Part B carrier for the professional services of PA's furnished to hospital patients and payment is always made to the PA's employer or contractor at 85% of the physician fee schedule. Since PAs cannot bill the program directly for their professional services, they do not have the option to reassign payment for their professional services to their employer or contractor. However, in the case where a hospital is the PA's employer or contractor, the hospital must bill the program for the PA's professional services furnished to its patients. Payment for PA services is made only on an assignment-related basis.

NPs are identified on the provider file with specialty code50. CNSs are identified on the provider file by specialty code 89. PAs are identified on the provider file by specialty code 97.

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 Certified Nurse-Midwife Services

(Rev. 2024, Issued: 08-06-10, Effective: 01-01-11, Implementation: 01-03-11)

Payment for certified nurse-midwife (CNM) services is made directly to CNMs for their professional services, and for services furnished incident to their professional services. Also, CNMs are required to accept assigned payment for their services. Accordingly, when CNMs bill for their services under specialty code 42, billing does not have to flow through a physician or facility unless the CNM reassigns their benefits to another billing entity. For reassigned CNM services, the entity bills for CNM services using the specialty code 42 to signify that payment for CNM services is being claimed.

Prior to December 31, 1991, Medicare Part B payment for CNM services was made at 80 percent of the lesser of the actual charge or, under a fee schedule that did not exceed 65 percent of the prevailing charge. This payment methodology changed and effective

January 1, 1992, until December 31, 2010, payment for CNM services is made at 80 percent of the lesser of the actual charge, or 65 percent of the physician fee schedule amount for the same service performed by a physician. However, effective on and after January 1, 2011, payment for CNM services is made at 80 percent of the lesser of the actual charge, or 100 percent of the physician fee schedule amount for the same service performed by a physician.

Payment for covered drugs and biologicals furnished incident to CNMs' services is made according to the Part B drug/biological payment methodology. Covered clinical diagnostic lab services furnished by CNMs are paid according to the clinical diagnostic lab fee schedule. Also, when CNMs furnish outpatient treatment services for mental illnesses, these services could be subject to the outpatient mental health treatment limitation (the limitation). The appropriate percentage payment reduction under the limitation is applied first to the approved amount for the mental health treatment services before the actual payment amount is determined for the CNMs' services. Please refer to §210 of this manual to determine the appropriate percentage payment reduction under the limitation.

130.2 - Global Allowances

(Rev. 2024, Issued: 08-06-10, Effective: 01-01-11, Implementation: 01-03-11)

When a certified nurse-midwife is providing most of the care to a Medicare beneficiary that is part of a global service and a physician also provides a portion of the care for this same global service, the fee paid to the CNM for his or her care is based on the portion of the global fee that would have been paid to the physician for the care provided by the CNM.

For example, a CNM requests that the physician examine the beneficiary prior to delivery. The CNM has furnished 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 CNM'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 certified nurse-midwife (65% x $970, effective January 1, 1992 thru December 31, 2010.)	$ 630.50
Fee schedule amount for certified nurse-midwife (100% x 970, effective January 1, 2011.)	$970.00

Therefore, the certified nurse-midwife would be paid no more than 80 percent of $630.50, or

80 percent of $970.00 for services furnished on or after January 1, 2011, for the care of the beneficiary.

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

Physicians and certified 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. 704, Issued: 10-07-05, Effective: 11-07-05, Implementation: 11-07-05)

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. However, effective August 1, 2005, CMS will discontinue sending the Biannual Recertification list for CRNAs to carriers.

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. 704, Issued: 10-07-05, Effective: 11-07-05, Implementation: 11-07-05)

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. However, effective August 1, 2005 CMS will discontinue sending the Biannual Recertification list for CRNAs to carriers. The CRNA recertification list was instituted prior to current enrollment procedures and is no longer deemed necessary.

CMS requires contractors to verify a CRNA's qualifications when he or she first enrolls in Medicare. With respect to recertification, CRNA's typically only need to submit a recertification application and accompanying fee to the State. No recertification testing is required, thus greatly reducing the need for the ongoing review of a CRNA's credentials. In addition, since no other specialty has a similar biannual recertification list, CRNA's will now be handled the same as any other specialty so as to ensure uniformity.

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 l05 of Claim Detail l on an EMC bill), or;

  "CRNA or AA services have not been medically directed," (indicate "B" in field 41, location l05 of Claim Detail l 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 anesthetists 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

140.5 - Payment for Anesthesia Services Furnished by a Teaching CRNA

(Rev. 1859; Issued: 11-20-09; Effective Date: For services furnished on or after 01-01-10; Implementation Date: 01-04-10)

Payment can be made under Part B to a teaching CRNA who supervises a single case involving a student nurse anesthetist where the CRNA is continuously present. The CRNA reports the service using the usual “QZ” modifier. This modifier designates that the teaching CRNA is **not** medically directed by an anesthesiologist. No payment is made under Part B for the service provided by a student nurse anesthetist.

The American Association of Nurse Anesthetists (AANA) indicates that their standards for approved nurse anesthetist training programs allow teaching CRNAs to supervise two

concurrent cases involving student nurse anesthetists. You may allow payment, as follows, if a teaching CRNA is involved with two student nurse anesthetists and the service is furnished on or after August 1, 2002:

- Recognize the full base units (assigned to the anesthesia code) where the teaching CRNA is present with the student nurse anesthetist throughout pre and post anesthesia care; and

- Recognize the actual time the teaching CRNA is personally present with the student nurse anesthetist. Anesthesia time may be discontinuous. For example, a teaching CRNA is involved in two concurrent cases with student nurse anesthetists. Case 1 runs from 9:00 a.m. to 11:00 a.m. and case 2 runs from 9:45 a.m. to 11:30 a.m. The teaching CRNA is present in case 1 from 9:00 a.m. to 9:30 a.m. and from 10:15 a.m. to 10:30 a.m.. From 9:45 a.m. to 10:14 a.m. and from 10:31 a.m. to 11:30 a.m., the CRNA is present in case 2. The CRNA may report 45 minutes of anesthesia time for case 1 (i.e., 3 time units) and 88 minutes (i.e., 5.9 units) of anesthesia time for case 2.

The teaching CRNA must document his/her involvement in cases with student nurse anesthetists. The documentation must be sufficient to support the payment of the fee and available for review upon request.

For services furnished on or after January 1, 2010, the teaching CRNA, not under the medical direction of a physician, can be paid for his/her involvement in each of two concurrent cases with student nurse anesthetists. Allow payment at the regular fee schedule rate if the teaching CRNA is involved with two concurrent student nurse anesthetist cases. The CRNA reports the anesthesia service using the “QZ” modifier.

To bill the anesthesia base units, instruct the CRNA that he/she must be present with the student nurse anesthetist during the pre and post anesthesia care for each of the two cases.

To bill anesthesia time for each case, instruct the teaching CRNA that he/she must continue to devote his/her time to the two concurrent cases and not be involved in other activities. The teaching CRNA can decide how to allocate his or her time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient’s health status and other factors.

The teaching CRNA must document his/her involvement in the cases with the student nurse anesthetists.

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. 1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)

All covered therapeutic services furnished by qualified CPs are subject to the outpatient mental health treatment limitation (the limitation). Generally, the limitation does not apply to diagnostic services. Refer to §210 below for a discussion of the outpatient mental health treatment 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. 999, Issued: 07-14-06; Effective: 01-01-05; Implementation: 10-02-06)

The Medicare Benefit Policy Manual, Chapter 15, contains requirements for coverage for medical and other health services including those of physicians and non-physician practitioners.

Care plan oversight (CPO) is the physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare-covered services provided by a participating home health agency or Medicare approved hospice.

CPO services 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.

The CPO services require recurrent physician supervision of a patient involving 30 or more minutes of the physician's time per month. 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 into 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. The physician who bills for CPO must be the same physician who signs the plan of care.

Nurse practitioners, physician assistants, and clinical nurse specialists, practicing within the scope of State law, may bill for care plan oversight. These non-physician practitioners must have been providing ongoing care for the beneficiary through evaluation and management services. These non-physician practitioners may not bill for CPO if they have been involved only with the delivery of the Medicare-covered home health or hospice service.

A. Home Health CPO

Non-physician practitioners can perform CPO only if the physician signing the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for CPO and either:

- The physician and NPP are part of the same group practice; or
- If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP; or
- If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice.

Billing may be made for care plan oversight services furnished by an NPP when:

- The NPP providing the care plan oversight has seen and examined the patient;

- The NPP providing care plan oversight is not functioning as a consultant whose participation is limited to a single medical condition rather than multidisciplinary coordination of care; and

- The NPP providing care plan oversight integrates his or her care with that of the physician who signed the plan of care.

NPPs may not certify the beneficiary for home health care.

B. Hospice CPO

The attending physician or nurse practitioner (who has been designated as the attending physician) may bill for hospice CPO when they are acting as an "attending physician". An "attending physician" is one who has been identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care. They are not employed nor paid by the hospice. The care plan oversight services are billed using Form CMS-1500 or electronic equivalent.

For additional information on hospice CPO, see Chapter 11, §40.1.3.1 of this manual.

180.1 - Care Plan Oversight Billing Requirements

(Rev. 999, Issued: 07-14-06; Effective: 01-01-05; Implementation: 10-02-06)

A. Codes for Which Separate Payment May Be Made

Effective January 1, 1995, separate payment may be made for CPO oversight services for 30 minutes or more if the requirements specified in the Medicare Benefits Policy Manual, Chapter 15 are met.

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 for CPO services 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 and recertification and development of plans of care for Medicare-covered home health services were created. See the Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-01, Chapter 4, "Physician Certification and Recertification of Services," §10-60, and the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, "Home Health Services", §30.

The home health agency certification code 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 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. The home health agency recertification code 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 was 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.

NOTE: There is currently no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice provider number required for a care plan oversight claim. For this reason, the requirement to include the HHA or hospice provider number on a care plan oversight claim is temporarily waived until a new version of this electronic standard format is adopted under HIPAA and includes a place to provide the HHA and hospice provider numbers for care plan oversight claims.

190 - Medicare Payment for Telehealth Services

(Rev. 1, 10-01-03)

A3-3497, A3-3660.2, B3-4159, B3-15516

190.1 - Background

(Rev. 1635, Issued: 11-14-08, Effective: 01-01-09, Implementation: 01-05-09)

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 (HPSA) 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.

Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended §1834 of the Act to add certain entities as originating sites for payment of telehealth services. Effective for services furnished on or after January 1, 2009, eligible originating sites include a hospital-based or critical access hospital-based renal dialysis center (including satellites); a skilled nursing facility (as defined in §1819(a) of the Act); and a community mental health center (as defined in §1861(ff)(3)(B) of the Act). MIPPA also amended§1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under §1834(m)(4)(C)(ii)(VII) from the consolidated billing provisions of the skilled nursing facility prospective payment system (SNF PPS).

NOTE: MIPPA did not add independent renal dialysis facilities as originating sites for payment of telehealth services.

The telehealth provisions authorized by §1834(m) of the Act are implemented in 42 CFR 410.78 and 414.65.

190.2 - Eligibility Criteria

(Rev. 1635, Issued: 11-14-08, Effective: 01-01-09, Implementation: 01-05-09)

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 an 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);

A federally qualified health center (FQHC);

A hospital-based or critical access hospital-based renal dialysis center (including satellites) (effective January 1, 2009);

A skilled nursing facility (SNF) (effective January 1, 2009); and

A community mental health center (CMHC) (effective January 1, 2009).

NOTE: Independent renal dialysis facilities are not eligible originating sites.

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. 2354, Issued: 11-18-11, Effective: 01-01-12, Implementation: 01-03-12)

The use of a telecommunications system may substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. The various services and corresponding current procedure terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed below.

- Consultations (CPT codes 99241 - 99275) - Effective October 1, 2001 – December 31, 2005;

- Consultations (CPT codes 99241 - 99255) - Effective January 1, 2006 – December 31, 2009;

- Telehealth consultations, emergency department or initial inpatient (HCPCS codes G0425 – G0427) - Effective January 1, 2010;

- Follow-up inpatient telehealth consultations (HCPCS codes G0406, G0407, and G0408) - Effective January 1, 2009;

- Office or other outpatient visits (CPT codes 99201 - 99215);

- Subsequent hospital care services, with the limitation of one telehealth visit every 3 days (CPT codes 99231, 99232, and 99233) – Effective January 1, 2011;

- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days (CPT codes 99307, 99308, 99309, and 99310) – Effective January 1, 2011;

- Pharmacologic management (CPT code 90862);

- Individual psychotherapy (CPT codes 90804 - 90809); Psychiatric diagnostic interview examination (CPT code 90801) – Effective March 1, 2003;

- Neurobehavioral status exam (CPT code 96116) - Effective January 1, 2008;

- End Stage Renal Disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) – Effective January 1, 2005 – December 31, 2008;

- End Stage Renal Disease (ESRD) related services (CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961) – Effective January 1, 2009;

- Individual and group medical nutrition therapy (HCPCS codes G0270, 97802, 97803, and 97804) – Individual effective January 1, 2006; group effective January 1, 2011;

- Individual and group health and behavior assessment and intervention (CPT codes 96150 – 96154) – Individual effective January 1, 2010; group effective January 1, 2011.

- Individual and group kidney disease education (KDE) services (HCPCS codes G0420 and G0421) – Effective January 1, 2011; and

- Individual and group diabetes self-management training (DSMT) services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training (HCPCS codes G0108 and G0109) - Effective January 1, 2011.

- Smoking Cessation Services (CPT codes 99406 and 99407and HCPCS codes G0436 and G0437) – Effective January 1, 2012.

NOTE: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits.

190.3.1 - Telehealth Consultation Services, Emergency Department or Initial Inpatient versus Inpatient Evaluation and Management (E/M) Visits

(Rev. 2354, Issued:11-18-11 Effective: 01-01-12, Implementation: 01-03-12)

A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified nonphysician practitioner (NPP) at the request of another physician or appropriate source.

Section 1834(m) of the Social Security Act includes "professional consultations" in the definition of telehealth services. Inpatient or emergency department consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site.

The use of a telecommunications system may substitute for an in-person encounter for emergency department or initial and follow-up inpatient consultations.

Medicare contractors pay for reasonable and medically necessary inpatient or emergency department telehealth consultation services furnished to beneficiaries in hospitals or SNFs when all of the following criteria for the use of a consultation code are met:

- An inpatient or emergency department consultation service is distinguished from other inpatient or emergency department evaluation and management (E/M) visits because it is provided by a physician or qualified nonphysician practitioner (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The qualified NPP may perform consultation services within the scope of practice and licensure requirements for NPPs in the State in which he/she practices;

- A request for an inpatient or emergency department telehealth consultation from an appropriate source and the need for an inpatient or emergency department telehealth consultation (i.e., the reason for a consultation service) shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and

- After the inpatient or emergency department telehealth consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician.

The intent of an inpatient or emergency department telehealth consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge.

Unlike inpatient or emergency department telehealth consultations, the majority of subsequent inpatient hospital, emergency department and nursing facility care services require in-person visits to facilitate the comprehensive, coordinated, and personal care that medically volatile, acutely ill patients require on an ongoing basis.

Subsequent hospital care services are limited to one telehealth visit every 3 days. Subsequent nursing facility care services are limited to one telehealth visit every 30 days.

190.3.2 - Telehealth Consultation Services, Emergency Department or Initial Inpatient Defined

(Rev. 2354, Issued: 11-18-11, Effective: 01-01-12, Implementation: 01-03-12)

Emergency department or initial inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the emergency department or initial inpatient consultation via telehealth cannot be the physician of record or the attending physician, and the emergency department or

initial inpatient telehealth consultation would be distinct from the care provided by the physician of record or the attending physician. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Emergency department or initial inpatient telehealth consultations are subject to the criteria for emergency department or initial inpatient telehealth consultation services, as described in section 190.3.1 of this chapter.

Payment for emergency department or initial inpatient telehealth consultations includes all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim labwork) and communicating with other professionals or family members. Intra-service activities must include the three key elements described below for each procedure code. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional E/M service could be billed for work related to an emergency department or initial inpatient telehealth consultation.

Emergency department or initial inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused history, conducting a problem focused examination, and engaging in medical decision making that is straightforward, would bill HCPCS code G0425 (Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth).

- Practitioners taking a detailed history, conducting a detailed examination, and engaging in medical decision making that is of moderate complexity, would bill HCPCS code G0426 (Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth).

- Practitioners taking a comprehensive history, conducting a comprehensive examination, and engaging in medical decision making that is of high complexity, would bill HCPCS code G0427 (Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth).

Although emergency department or initial inpatient telehealth consultations are specific to telehealth, these services must be billed with either the -GT or -GQ modifier to identify the telehealth technology used to provide the service. See section 190.6 of this chapter for instructions on how to use these modifiers.

190.3.3 - Follow-Up Inpatient Telehealth Consultations Defined

(Rev. 2168, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

Follow-up inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs via telehealth to follow up on an initial consultation, or subsequent consultative visits requested by the attending physician. The initial inpatient consultation may have been provided in-person or via telehealth.

Follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs.

The physician or practitioner who furnishes the inpatient follow-up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by the physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow-up inpatient consultation. Follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3.1 of this chapter.

Payment for follow-up inpatient telehealth consultations includes all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim labwork) and communicating with other professionals or family members. Intra-service activities must include at least two of the three key elements described below for each procedure code. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional evaluation and management service could be billed for work related to a follow-up inpatient telehealth consultation.

Follow-up inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused interval history, conducting a problem focused examination, and engaging in medical decision making that is straightforward or of low complexity, would bill a limited service, using HCPCS code G0406 (Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth).

- Practitioners taking an expanded focused interval history, conducting an expanded problem focused examination, and engaging in medical decision making that is of moderate complexity, would bill an intermediate service using HCPCS code

G0407(Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth).

- Practitioners taking a detailed interval history, conducting a detailed examination, and engaging in medical decision making that is of high complexity, would bill a complex service, using HCPCS code G0408 (Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth).

Although follow-up inpatient telehealth consultations are specific to telehealth, these services must be billed with either the -GT or -GQ modifier to identify the telehealth technology used to provide the service. (See section 190.6 of this chapter for instructions on how to use these modifiers.)

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. 790, Issued: 12-23-05; Effective: 01-01-06; Implementation: 04-03-06)

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.

If the physician or practitioner at the distant site is located in a critical access hospital (CAH) that has elected Method II, and the physician or practitioner has reassigned his/her benefits to the CAH, the CAH bills its regular FI for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

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.*

Registered dietitian or nutrition professional.

*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. 2354, Issued: 11-18-11, Effective: 01-01-12, Implementation: 01-03-12)

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

The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification.

For telehealth services furnished from October 1, 2001, through December 31, 2002, the originating site facility fee is the lesser of $20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the originating site facility fee is updated by the Medicare Economic Index. The updated fee is included in the Medicare Physician Fee Schedule (MPFS) Final Rule, which is published by November 1 prior to the start of the calendar year for which it is effective. The updated fee for each calendar year is also issued annually in a Recurring Update Notification instruction for January of each year.

3. Payment amount:

The originating site facility fee is a separately billable Part B payment. The payment amount to the originating site is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, except CAHs. 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 (OPPS). Payment is not based on the OPPS payment methodology.

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 separately from the cost-based reimbursement methodology. For CAH's, the payment amount is 80 percent of the originating site facility fee.

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 80 percent of the actual charge or 80 percent of the originating site facility fee, 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 MPFS.

Hospital-based or critical access-hospital based renal dialysis center (or their satellites). When a hospital-based or critical access hospital-based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or MCP amount.

Skilled nursing facility (SNF). The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. The originating site facility fee is a separately billable Part B payment.

Community Mental Health Center (CMHC). The originating site facility fee is not a partial hospitalization service. The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization services. The originating site facility fee is not bundled in the per diem payment for partial hospitalization. The originating site facility fee is a separately billable Part B payment.

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." 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. Deductible and coinsurance rules apply to Q3014. By submitting Q3014 HCPCS code, the originating site authenticates they are located in either a rural HPSA or non-MSA county.

This benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X 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 a 12X 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. All RHCs and FQHCs must use revenue code 078X when billing for the originating site facility fee. For all other non-RHC/FQHC services, provider based RHCs and FQHCs must bill using the base 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 using revenue code 078X.

Hospital-based or CAH-based renal dialysis centers (including satellites) bill their local FIs and/or Part A MACs for the originating site facility fee. Telehealth bills originating in renal dialysis centers must be submitted on a 72X TOB. All hospital-based or CAH-based renal dialysis centers (including satellites) must use revenue code 078X when billing for the originating site facility fee. The renal dialysis center serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary.

Skilled nursing facilities (SNFs) bill their local FIs and/or Part A MACs for the originating site facility fee. Telehealth bills originating in SNFs must be submitted on TOB 22X or 23X. For SNF inpatients in a covered Part A stay, the originating site facility fee must be submitted on a 22X TOB. All SNFs must use revenue code 078X

when billing for the originating site facility fee. The SNF serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary.

Community mental health centers (CMHCs) bill their local FIs and/or Part A MACs for the originating site facility fee. Telehealth bills originating in CMHCs must be submitted on a 76X TOB. All CMHCs must use revenue code 078X when billing for the originating site facility fee. The CMHC serving as an originating site must bill for HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the beneficiary. Note that Q3014 does not count towards the number of services used to determine per diem payments for partial hospitalization services.

The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners
(Rev. 1716, Issued: 04-24-09; Effective: 01-01-09; Implementation: 05-26-09)

Claims for telehealth services are submitted to the contractors that process claims for the performing physician/practitioner's service area. Physicians/practitioners submit the appropriate HCPCS 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. By coding and billing the "GT" modifier with a covered ESRD-related service telehealth code, the distant site physician/practitioner certifies that 1 visit per month was furnished face-to-face "hands on" to examine the vascular access site. Refer to Pub. 100-02, chapter 15, section 270.4.1 for the conditions of telehealth payment for ESRD-related services.

In situations where a CAH has elected payment Method II for CAH outpatients, and the practitioner has reassigned his/her benefits to the CAH, FIs should make payment for telehealth services provided by the physician or practitioner at 80 percent of the MPFS amount for the distant site service. In all other cases, except for MNT services as discussed in Section 190.7-Contractor Editing of Telehealth Claims, telehealth services provided by the physician or practitioner at the distant site are billed to the carrier.

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 - Contractor Editing of Telehealth Claims

(Rev. 997, Issued: 07-07-06; Effective: 01-01-06; Implementation: 08-07-06)

Medicare telehealth services (as listed in section 190.3) are billed with either the “GT” or “GQ” modifier. The contractor shall approve covered telehealth services if the physician or practitioner is licensed under State law to provide the service. Contractors 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 contractor shall install edits to ensure that only properly licensed physicians and practitioners are paid for covered telehealth services.

If a contractor 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 contractor 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 contractor denies telehealth services because the physician or practitioner may not bill for them, the contractor uses MSN message 21.18: “This item or service is not covered when performed or ordered by this practitioner.” The contractor uses remittance advice message 52 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 contractor 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 contractor uses B18 as the explanation for the denial of the claim.

The only claims from institutional facilities that FIs shall pay for telehealth services at the distant site, except for MNT services, are for physician or practitioner services when the distant site is located in a CAH that has elected Method II, and the physician or

practitioner has reassigned his/her benefits to the CAH. The CAH bills its regular FI for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

Claims from hospitals or CAHs for MNT services are submitted to the hospital's or CAH's regular FI. Payment is based on the non-facility amount on the Medicare Physician Fee Schedule for the particular HCPCS codes.

200 - Allergy Testing and Immunotherapy

(Rev. 504, Issued: 03-11-05, Effective/Implementation: N/A)

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 vespid 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 vespid 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**. - Code 95165 represents preparation of vials of non-venom antigens. As in the case of venoms, some non-venom antigens cannot 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. In establishing the practice expense component for mixing a multidose vial of antigens, we observed that the most common practice was to prepare a 10 cc vial; we also observed that the most common use was to remove aliquots with a volume of 1 cc. Our PE computations were based on those facts. Therefore, a physician's removing 10 1cc aliquot doses captures the entire PE component for the service.

This does not mean that the physician must remove 1 cc aliquot doses from a multidose vial. It means that the practice expenses payable for the preparation of a 10cc vial remain the same irrespective of the size or number of aliquots removed from the vial. Therefore, a physician may not bill this vial preparation code for more than 10 doses per vial; paying more than 10 doses per multidose vial would significantly overpay the practice expense component attributable to this service. (Note that this code does not include the injection of antigen(s); injection of antigen(s) is separately billable.)

When a multidose vial contains less than 10cc, physicians should bill Medicare for the number of 1 cc aliquots that may be removed from the vial. That is, a physician may bill Medicare up to a maximum of 10 doses per multidose vial, but should bill Medicare for fewer than 10 doses per vial when there is less than 10cc in the vial.

If it is medically necessary, physicians may bill Medicare for preparation of more than one multidose vial.

EXAMPLES:

(1) If a 10cc multidose vial is filled to 6cc with antigen, the physician may bill Medicare for 6 doses since six 1cc aliquots may be removed from the vial.

If a 5cc multidose vial is filled completely, the physician may bill Medicare for 5 doses for this vial.

(3) If a physician removes ½ cc aliquots from a 10cc multidose vial for a total of 20 doses from one vial, he/she may only bill Medicare for 10 doses. Billing for more than 10 doses would mean that Medicare is overpaying for the practice expense of making the vial.

(4) If a physician prepares two 10cc multidose vials, he/she may bill Medicare for 20 doses. However, he/she may remove aliquots of any amount from those vials. For example, the physician may remove ½ aliquots from one vial, and 1cc aliquots from the other vial, but may bill no more than a total of 20 doses.

(5) If a physician prepares a 20cc multidose vial, he/she may bill Medicare for 20 doses, since the practice expense is calculated based on the physician's removing 1cc aliquots from a vial. If a physician removes 2cc aliquots from this vial, thus getting only 10 doses, he/she may nonetheless bill Medicare for 20 doses because the PE for 20 doses reflects the actual practice expense of preparing the vial.

(6) If a physician prepares a 5cc multidose vial, he may bill Medicare for 5 doses, based on the way that the practice expense component is calculated. However, if the physician removes ten ½ cc aliquots from the vial, he/she may still bill only 5 doses because the practice expense of preparing the vial is the same, without regard to the number of additional doses that are removed from the vial.

C. Allergy Shots and Visit Services on the Same Day

At the outset of the physician fee schedule, the question was posed as to whether visits should be billed on the same day as an allergy injection (CPT codes 95115-95117), since these codes have status indicators of A rather than T. Visits should not be billed with allergy injection services 95115 or 95117 unless the visit represents another separately identifiable service. This language parallels CPT editorial language that accompanies the allergen immunotherapy codes, which include codes 9515 and 95117. Prior to January 1, 1995, you appeared to be enforcing this policy through three (3) different means:

- Advising physician to use modifier 25 with the visit service;
- Denying payment for the visit unless documentation has been provided; and
- Paying for both the visit and the allergy shot if both are billed for.

For services rendered on or after January 1, 1995, you are to enforce the requirement that visits not be billed and paid for on the same day as an allergy injection through the following means. Effective for services rendered on or after that date, the global surgery policies will apply to all codes in the allergen immunotherapy series, including the allergy shot codes 95115 and 95117. To accomplish this, CMS changed the global surgery indicator for allergen immunotherapy codes from XXX, which meant that the global surgery concept did not apply to those codes, to 000, which means that the global surgery concept applies, but that there are no days in the postoperative global period. Now that the global surgery policies apply to these services, you are to rely on the use of modifier 25 as the only means through which you can make payment for visit services provided on the same day as allergen immunotherapy services. In order for a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series (i.e., any service in the series from 95115 through 95199), the physician is to bill a modifier 25 with the visit code, indicating that the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

D. Reasonable Supply of Antigens

See CMS Manual System, Internet Only Manual, Medicare Benefits Policy Manual, CMS Pub. 100-02 Chapter 15, section 50.4.4, regarding the coverage of antigens, including what constitutes a reasonable supply of antigens.

210 - Outpatient Mental Health Treatment Limitation

(Rev. 2166, Issued: 02-25-11, Effective: 03-25-11, Implementation: 03-25-11)

Regardless of the actual expenses a beneficiary incurs in connection with the 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 approved amount for those services. This limitation is called the outpatient mental health treatment limitation (the limitation). The 62.5 percent limitation has been in place since the inception of the Medicare Part B program and it will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:

- January 1, 2010 – December 31, 2011, the limitation percentage is 68.75%. (Medicare pays 55% and the patient pays 45%).

- January 1, 2012 – December 31, 2012, the limitation percentage is 75%. (Medicare pays 60% and the patient pays 40%).

- January 1, 2013 – December 31, 2013, the limitation percentage is 81.25%. (Medicare pays 65% and the patient pays 35%).

- January 1, 2014 – onward, the limitation percentage is 100%. (Medicare pays 80% and the patient pays 20%).

For additional details concerning computation of the limitation, please see the examples under section 210.1 E.

210.1 - Application of the Limitation

(Rev. 2166, Issued: 02-25-11, Effective: 03-25-11, Implementation: 03-25-11)

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 a 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 the Limitation

The term "mental, psychoneurotic, and personality disorders" is defined as the specific psychiatric diagnoses described in the International Classification of Diseases, 9th Revision (ICD-9), under the code range 290-319.

When the treatment services rendered are both for a psychiatric diagnosis as defined in the ICD-9 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 ICD-9 under the code range 290-319 that represents mental, psychoneurotic and personality disorders, 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 the Limitation

Medicare Contractors must 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, nurse practitioners, clinical nurse specialists and physician assistants. Items and supplies furnished by physicians or other mental health practitioners in connection with treatment are also subject to the limitation.

Generally, Medicare Contractors must apply the limitation only to treatment services. However, diagnostic psychological and neuropsychological 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 the Limitation

1. Diagnosis of Alzheimer's Disease or Related Disorder - When the primary diagnosis reported for a particular service is Alzheimer's Disease or an Alzheimer's related disorder, Medicare Contractors must look to the nature of the service that has been rendered in determining whether it is subject to the limitation. Alzheimer's disease is coded 331.0 in the "International Classification of Diseases, 9th Revision", which is outside the code range 290-319 that represents mental, psychoneurotic and personality disorders. Additionally, Alzheimer's related disorders are identified by contractors under ICD-9 codes that are within the 290-319 code range (290.XX or others as contractors determine appropriate) or outside the 290-319 code range as determined appropriate by contractors. When the primary treatment rendered to a patient with a diagnosis of Alzheimer's disease or a related disorder is psychotherapy, it is subject to the limitation. However, 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 (such as described under CPT code 90862 or any successor code) and is not subject to the limitation. CPT code 90862 describes pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

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 or any successor code (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 or any successor code.

3. Diagnostic Services –Medicare Contractors do not apply the limitation to psychiatric diagnostic evaluations and diagnostic psychological and neuropsychological tests performed to establish or confirm the patient's diagnosis. Diagnostic services include psychiatric diagnostic evaluations billed under CPT codes 90801 or 90802 (or any successor codes) and, psychological and neuropsychological tests billed under CPT code range 96101-96118 (or any successor code range).

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, contractors must 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, Medicare contractors must 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, Medicare contractors may find it necessary to request documentation to justify the reason for more than one diagnostic visit.

4. Partial Hospitalization Services Not Directly Provided by a Physician or a Practitioner - The limitation does not apply to partial hospitalization services that are not directly provided by a physician, clinical psychologist, nurse practitioner, clinical nurse specialist or a physician assistant. Partial hospitalization services are billed by hospital outpatient departments and community mental health centers (CMHCs) to Medicare Contractors. However, services furnished by physicians, clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants to partial hospitalization patients are billed separately from the partial hospitalization program of services. Accordingly, these professional's mental health services to partial hospitalization patients are paid under the physician fee schedule by Medicare Contractors and may be subject to the limitation. (See chapter 4, section 260.1C).

E. Computation of Limitation

Medicare Contractors determine the Medicare approved payment amount for services subject to the limitation. They:

- Multiply the approved amount by the limitation percentage amount;
- 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 Medicare approved amount.

The following examples illustrate the application of the limitation in various circumstances as it is gradually reduced under section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA). Please note that although the calendar year 2009 Part B deductible of $135 is used under these examples, the actual deductible amount for calendar year 2010 and future years is unknown and will be subject to change.

Example #1: In 2010, a clinical psychologist submits a claim for $200 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $180. Since clinical psychologists must accept assignment, the patient is not liable for the $20 in excess charges. The patient previously satisfied the $135 annual Part B deductible. The limitation reduces the amount of incurred expenses to 68 ¾ percent of the approved amount. Medicare pays 80 percent of the remaining incurred expenses. The Medicare payment and patient liability are computed as follows:

1. Actual charges…….…….$200.00
2. Medicare-approved amount…….…….……$180.00
3. Medicare incurred expenses (0.6875 x line 2)……..….……...$123.75
4. Unmet deductible……..…$0.00
5. Remainder after subtracting deductible (line 3 minus line 4)……...$123.75
6. Medicare payment (0.80 x line 5)…….$99.00
7. Patient liability (line 2 minus line 6)…….$81.00

Example #2: In 2012, a clinical social worker submits a claim for $135 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $120. Since clinical social workers must accept assignment, the patient is not liable for the $15 in excess charges. The limitation reduces the amount of incurred expenses to 75 percent of the approved amount. The patient previously satisfied $70 of the $135 annual Part B deductible, leaving $65 unmet. The Medicare payment and patient liability are computed as follows:

1. Actual charges…….….$135.00
2. Medicare-approved amount…….....$120.00
3. Medicare incurred expenses (0.75 x line 2)……..…….$90.00
4. Unmet deductible……..…….$65.00
5. Remainder after subtracting deductible (line 3 minus line 4)……....$25.00
6. Medicare payment (0.80 x line 5)……...$20.00
7. Patient liability (line 2 minus line 6)…….....$100.00

Example #3: In calendar year 2013, a physician who does not accept assignment submits a claim for $780 for services in connection with the treatment of a mental disorder that did not require inpatient hospitalization. The Medicare-approved amount is $750. Because the physician does not accept assignment, the patient is liable for the $30 in

excess charges. The patient has not satisfied any of the $135 Part B annual deductible. The Medicare payment and patient liability are computed as follows:

1. Actual charges…….…….$780.00
2. Medicare-approved amount……..$750.00
3. Medicare incurred expenses (0.8125 x line 2)……..$609.38
4. Unmet deductible……..$135.00
5. Remainder after subtracting deductible (line 3 minus line 4)……...$474.38
6. Medicare payment (0.80 x line 5)…….$379.50
7. Patient liability (line 1 minus line 6)……$400.50

Example #4: A patient's Part B expenses during calendar year 2014 are for a physician's services in connection with the treatment of a mental disorder that initially required inpatient hospitalization, with subsequent physician services furnished on an outpatient basis. The patient has not satisfied any of the $135 Part B deductible. The physician accepts assignment and submits a claim for $780. The Medicare-approved amount is $750. Since the limitation will be completely phased out as of January 1, 2014, the entire $750 Medicare-approved amount is recognized as the total incurred expenses because such expenses are no longer reduced. Also, there is no longer any distinction between mental health services the patient receives as an inpatient or outpatient. The Medicare payment and patient liability are computed as follows:

1. Actual charges……..$780.00
2. Medicare-approved amount……..$750.00
3. Medicare incurred expenses (1.00 x line 2)……..$750.00
4. Unmet deductible……..$135.00
5. Remainder after subtracting deductible (line 3 minus line 4)……...$615.00
6. Medicare payment (0.80 x line 5)…….$492.00

Beneficiary liability (line 2 minus line 6)…….$258.00

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 <u>required</u>. However, the x-ray <u>may</u> 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.

230 - Primary Care Incentive Payment Program (PCIP)

(Rev. 2152, Issued: 02-11-11, Effective: 07-01-11, Implementation: 07-05-11)

Section 5501(a) of the Affordable Care Act revises section 1833 of the Social Security Act (the Act) by adding a new paragraph, (x), “Incentive Payments for Primary Care Services.” Section 1833(x) of the Act states that in the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, there shall be a 10 percent incentive payment for such services under Part B when furnished by a primary care practitioner.

Information regarding Primary Care Incentive Payment Program (PCIP) payments made to critical access hospitals (CAHs) paid under the optional method can be found in Pub. 100-04, Chapter 4, §250.12 of this manual.

230.1 - Definition of Primary Care Practitioners and Primary Care Services

(Rev. 2152, Issued: 02-11-11, Effective: 07-01-11, Implementation: 07-05-11)

Primary care practitioner is defined as:

1. A physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine for whom primary care services accounted for at least 60 percent of the allowed charges under the PFS (excluding hospital inpatient care and emergency department visits) for the practitioner in a prior period as determined appropriate by the Secretary; or

2. A nurse practitioner, clinical nurse specialist, or physician assistant for whom primary care services accounted for at least 60 percent of the allowed charges under the PFS (excluding hospital inpatient care and emergency department visits) for the practitioner in a prior period as determined appropriate by the Secretary.

Primary care services are defined as HCPCS Codes:

1. 99201 through 99215 for new and established patient office or outpatient evaluation and management (E/M) visits;

2. 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home or custodial care E/M services; and domiciliary, rest home or home care plan oversight services; and

3. 99341 through 99350 for new and established patient home E/M visits.

Practitioner Identification

Primary care practitioners will be identified using the National Provider Identifier (NPI) number of the rendering practitioner on claims. If the claim is submitted by a practitioner's group practice, the rendering practitioner's NPI must be included on the line-item for the primary care service and reflect an eligible HCPCS as identified. In order to be eligible for the PCIP, physician assistants, clinical nurse specialists, and nurse practitioners must be billing for their services under their own NPI and not furnishing services incident to physicians' services. Regardless of the specialty area in which they may be practicing, the specific nonphysician practitioners are eligible for the PCIP based on their profession and historical percentage of allowed charges as primary care services that equals or exceeds the 60 percent threshold.

The claims data used for the primary care percentage calculations depend on the potential primary care practitioner's date of enrollment in Medicare. We will use Medicare claims data 2 years prior to the PCIP payment year to determine PCIP eligibility for those potential primary care practitioners who were enrolled in Medicare in that year. For example, for CY 2011, we will use Medicare claims data from CY 2009 for practitioners who were already enrolled in Medicare in CY 2009. We will use claims data from the year immediately preceding the PCIP payment year in order to determine PCIP eligibility for potential primary care practitioners who newly enroll in Medicare in the year immediately preceding the PCIP payment year. For example, for CY 2011, we will use the available Medicare claims data from CY 2010 only for potential primary care practitioners who newly enrolled in Medicare in CY 2010.

Eligible practitioners for PCIP payments in a given calendar year who were enrolled in Medicare 2 years earlier will be listed by eligible NPI in the Primary Care Incentive

Payment Program Eligibility File, available after January 31 of the PCIP payment year on their Medicare contractor's website. Eligible practitioners for PCIP payments in a given calendar year who were newly enrolled in Medicare in the year immediate preceding the PCIP payment year will be identified in the PCIP Payment for New Providers Enrolled in Medicare File, available after October 1 of the PCIP payment year. Practitioners should contact their contractor with any questions regarding their eligibility for the PCIP.

230.2 - Coordination with Other Payments

(Rev. 2152, Issued: 02-11-11, Effective: 07-01-11, Implementation: 07-05-11)

Section 5501(a)(3) of the Affordable Care Act authorizes payment under the PCIP as an additional payment amount for specified primary care services without regard to any additional payment for the service under Section 1833(m) of the Act. Therefore, an eligible primary care physician furnishing a primary care service in a health professional shortage area (HPSA) may receive both a HPSA physician bonus payment (as described in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, §90.4) under the HPSA physician bonus program and a PCIP incentive payment under the new program beginning in CY 2011.

230.3 - Claims Processing and Payment

(Rev. 2152, Issued: 02-11-11, Effective: 07-01-11, Implementation: 07-05-11)

A. General Overview

Incentive payments will be made on a quarterly basis and shall be equal to 10 percent of the amount paid for such services under the Medicare Physician Fee Schedule (PFS) for those services furnished during the incentive payment year. PCIP payments for newly enrolled practitioners will be delayed due to the lag in their eligibility determination. Newly enrolled primary care practitioners will receive a single cumulative PCIP payment, retroactive for primary care services furnished from the beginning of the PCIP payment year, following the fourth quarter of the PCIP payment year after the primary care practitioner is deemed eligible. Quarterly payments will be made for subsequent incentive payments.

For information on PCIP payments to CAHs paid under the optional method, see the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, §250.12.

On an annual basis Medicare contractors shall receive a Primary Care Incentive Payment Program Eligibility File and PCIP Payment for New Providers Enrolled in Medicare File that they shall post to their websites. The files will list the NPIs of all practitioners who are eligible to receive PCIP payments for the PCIP payment year.

B. Method of Payment

- Calculate and pay qualifying primary care practitioners an additional 10 percent incentive payment.

- Calculate the payment based on the amount actually paid for the services, not the Medicare approved amount.

- Combine the PCIP incentive payments, when appropriate, with other incentive payments, including the HPSA physician bonus payment, and the HPSA Surgical Incentive Payment Program (HSIP) payment;

- Provide a special remittance form that is forwarded with the incentive payment so that physicians and practitioners can identify which type of incentive payment (HPSA physician and/or PCIP) was paid for which services.

- Practitioners should contact their contractor with any questions regarding PCIP payments.

C. Changes for Contractor Systems

The Medicare Carrier System, (MCS), Common Working File (CWF) and the National Claims History (NCH) shall be modified to accept a new PCIP indicator on the claim line. Once the type of incentive payment has been identified by the shared systems, the shared system shall modify their systems to set the indicator on the claim line as follows:

1 = HPSA;
2 = PSA;
3 = HPSA and PSA;
4 = HSIP;
5 = HPSA and HSIP;
6 = PCIP;
7 = HPSA and PCIP; and
Space = Not Applicable.

The contractor shared system shall send the HIGLAS 810 invoice for incentive payment invoices, including the new PCIP payment. The contractor shall also combine the provider's HPSA physician bonus, physician scarcity (PSA) bonus (if it should become available at a later date), HSIP payment and/or PCIP payment invoice per provider. The contractor shall receive the HIGLAS 835 payment file from HIGLAS showing a single incentive payment per provider.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R2464CP	05/04/2012	Enhance the Multi-Carrier System (MCS) and ViPS Medicare System (VMS) to Maintain Five Full Years of Pricing Data and to Automatically Price Claims/Adjustments at the Rates in Effect at the Dates of Service	10/01/2012 for VMS	7383
R2435CP	03/29/2012	Revised and Clarified Place of Service (POS) Coding Instructions – Rescinded and replaced by Transmittal 2561	10/01/2012	7631
R2407CP	02/03/2012	Revised and Clarified Place of Service (POS) Coding Instructions – Rescinded and replaced by Transmittal 2435	04/02/2012	7631
R2373CP	12/21/2011	Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Practices	01/03/2012	7502
R2354CP	11/18/2011	Expansion of Medicare Telehealth Services for CY 2012	01/03/2012	7504
R2303CP	09/14/2011	Teaching Physician Services	07/26/2011	7378
R2299CP	09/08/2011	Enhance the Multi-Carrier System (MCS) and ViPS Medicare System (VMS) to Maintain Five Full Years of Pricing Data and to Automatically Price Claims/Adjustments at the Rates in Effect at the Dates of Service – Rescinded and replaced by Transmittal 2464.	10/03/2011	7383
R2297CP	09/02/2011	Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician	01/03/2012	7502

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		Practices – Rescinded and replaced by Transmittal 2373		
R2282CP	08/26/2011	Clarification of Evaluation and Management Payment Policy	11/28/2011	7405
R2273CP	08/12/2011	Expansion of Medicare Telehealth Services for CY 2012 – Rescinded and replaced by Transmittal 2354	01/03/2012	7504
R2247CP	06/24/2011	Teaching Physician Services – Rescinded and replaced by Transmittal 2303	07/25/2011	7378
R2210CP	05/06/2011	Enhance the Multi-Carrier System (MCS) and ViPS Medicare System (VMS) to Maintain Five Full Years of Pricing Data and to Automatically Price Claims/Adjustments at the Rates in Effect at the Dates of Service – Rescinded and replaced by Transmittal 2299	10/03/2011	7383
R2168CP	02/28/2011	Expansion of Medicare Telehealth Services for CY 2011	01/03/2011 & 04/04/2011	7049
R2166CP	02/25/2011	Clarification to CR 6686-Outpatient Mental Health Treatment Limitation	03/25/2011	7307
R2161CP	02/25/2011	Incentive Payment Program for Primary Care Services, Section 5501(a) of the ACA	01/03/2011 & 04/04/2011	7060
R2159CP	02/15/2011	Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)	04/04/2011	7079
R2152CP	02/11/2011	Primary Care Incentive Payment Program (PCIP) Eligibility for New Providers Enrolled in Medicare	07/05/2011	7267
R2109CP	12/03/2010	Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services	04/04/2011	7079

Rev #	Issue Date	Subject	Impl Date	CR#
		(PPPS) – Rescinded and replaced by Transmittal 2159		
R2044CP	09/03/2010	Revisions and Re-issuance of Audiology Policies	09/30/2010	6447
R2040CP	08/27/2010	Section 5501(b) Incentive Payment Program for Major Surgical Procedures Furnished in Health Professional Shortage Areas of the Affordable Care Act (ACA)	01/03/2011 & 04/04/2011	7063
R2039CP	08/27/2010	Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Affordable Care Act (ACA) – Rescinded and replaced by Transmittal 2161	01/03/2011 & 04/04/2011	7060
R2032CP	08/20/2010	Expansion of Medicare Telehealth Services for CY 2011 – Rescinded and replaced by Transmittal 2168	01/03/2011	7049
R2024CP	08/06/2010	Payment for Certified Nurse-Midwife Services	01/03/2011	7005
R2007CP	07/23/2007	Revisions and Re-issuance of Audiology Policies – Rescinded and replaced by Transmittal 2044	08/11/2010	6447
R1975CP	05/28/2010	Revisions and Re-issuance of Audiology Policies - Rescinded and replaced by Transmittal 2007	07/28/2010	6447
R1931CP	03/12/2010	Revision of the Internet Only Manual (IOM) to Remove References to “Purchased Diagnostic Test” and Replace With Language Consistent With the Anti-Markup Rule	06/14/2010	6627
R1881CP	12/18/2009	Expansion of Medicare Telehealth Services for CY 2010	01/04/2010	6705
R1875CP	12/14/2009	Revisions to Consultation Services Payment Policy	01/04/2010	6740

Rev #	Issue Date	Subject	Impl Date	CR#
R1859CP	11/20/2009	MIPAA Section 139 Teaching Anesthesiologists	01/04/2010	6706
R1843CP	10/30/2009	Outpatient Mental Health Treatment Limitation	01/04/2010	6686
R1716CP	04/24/2009	List of Medicare Telehealth Services	05/26/2009	6458
R1643CP	12/05/2008	Indian Health Service (IHS) Provider Payment to Non-IHS Physicians for Teleradiology Interpretations	03/09/2009	6162
R1639CP	11/21/2008	Health Professional Shortage Area (HPSA) Bonus Payment Policy Changes	01/05/2009	6106
R1635CP	11/14/2008	Adding Certain Entities as Originating Sites for Payment of Telehealth Services-Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)	01/05/2009	6215
R1615CP	10/17/2008	Update to the Initial Preventive Physical Examination (IPPE) Benefit	01/05/2009	6223
R1604CP	09/26/2008	Physician Payment Amounts When Physicians Furnish Excluded Procedures in Ambulatory Surgical Centers (ASCs)	01/05/2009	6052
R1550CP	07/18/2008	Clarifications to Audiology Update Transmittal 1470, Change Request 5717	08/18/2008	6061
R1548CP	07/09/2008	Critical Care Visits and Neonatal Intensive Care (Codes 99291-99292)	07/07/2008	5993
R1545CP	06/27/2008	Payment for Inpatient Hospital Visits (Codes 99221-99239) – Rescinds and replaces Transmittal 1473.	04/07/2008	5792
R1530CP	06/06/2008	Critical Care Visits and Neonatal Intensive Care (Codes 99291-99292) - Rescinded and replaced by Transmittal 1548	07/07/2008	5993

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R1490CP	04/11/2008	Prolonged Services (Codes 99354-99359)	07/07/2008	5972
R1489CP	04/11/2008	Nursing Facility Services (Codes 99304-99318)	07/07/2008	5968
R1473CP	03/07/2008	Payment for Inpatient Hospital Visits – General (Codes 99221-99239) – Rescinded and replaced by Transmittal 1545.	04/07/2008	5792
R1470CP	02/29/2008	Update to Audiology Policies	04/07/2008	5717
R1466CP	02/22/2008	Payment for Hospital Observation Services (Codes 99217 - 99220) and Observation or Inpatient Care Services (Including Admission and Discharge Services - Codes 99234 - 99236)	04/07/2008	5791
R1465CP	02/22/2008	Payment for Initial Hospital Care Services (Codes 99221 - 99233) and Observation or Inpatient Care Services (Including Admission and Discharge Services) (Codes 99234 - 99236)	04/07/2008	5793
R1460CP	02/22/2008	Subsequent Hospital Visits and Hospital Discharge Day Management Services (Codes 99231 - 99239)	04/07/2008	5794
R1458CP	02/22/2008	Teaching Physician Requirements for ESRD Monthly Capitation Payment (MCP)	03/24/2008	5932
R1434CP	02/05/2008	Extension of the Dates of Service for the Physician Scarcity Area (PSA) Bonus Payment	01/07/2008	5937
R1324CP	08/27/2007	Anesthesia Services Furnished by the Same Physician Providing the Medical and Surgical Service	10/01/2007	5618
R1321CP	08/24/2007	Sunset of the Physician Scarcity Area (PSA) Bonus Payment	01/07/2008	5711

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R1316CP	08/17/2007	Anesthesia Services Furnished by the Same Physician Providing the Medical and Surgical Service – Replaced by Transmittal 1324	10/01/2007	5618
R1277CP	06/29/2007	Medicare Telehealth Services	01/07/2008	5628
R1273CP	06/29/2007	Billing and Payment in a Health Professional Shortage Area (HPSA)	10/01/2007	5625
R1168CP	01/26/2007	Direct Billing and Payments for Non-Physician Practitioner Services Furnished to Hospital Inpatients and Outpatients	04/26/2007	5221
R1026CP	08/11/2006	Medicare Telehealth Services	01/02/2007	5201
R999CP	07/14/2006	Non-Physician Practitioner (NPP) Payment for Care Plan Oversight	10/02/2006	4374
R997CP	07/07/2006	Medicare Telehealth Services Update	08/07/2006	5122
R993CP	06/23/2006	Non-Physician Practitioner (NPP) Payment for Care Plan Oversight	10/02/2006	4374
R979CP	06/09/2006	Cardiovascular System (Codes 92950-93799	07/10/2006	5048
R968CP	05/26/2006	Drug Administration Coding and Payment Policy Update to Pub. 100-04 Med. Claims Processing	06/26/2006	5028
R954CP	05/19/2006	Payment for Evaluation and Management Services Provided During Global Period of Surgery	08/20/2006	5025
R906CP	04/14/2006	Revision to Health Professional Shortage Area and Physician Scarcity Area Bonus Billing for Some Globally Billed Services	07/03/2006	5015
R834CP	02/03/2006	Revision to Health Professional Shortage Area and Physician Scarcity Area Bonus	07/03/2006	4266

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		Billing for Some Globally Billed Services		
R811CP	01/13/2006	Teaching Physician Services	02/13/2006	3928
R808CP	01/06/2006	Nursing Facility Services Codes (99304 – 99318	01/23/2006	4246
R807CP	01/06/2006	Revision to IOM 100-04, Chapter 12, Sections 90.4.1.1 and 90.4.2	02/06/2006	4182
R792CP	12/23/2005	Nursing Facility Services Codes (99304 – 99318) - Rescinded and replaced by Transmittal 808	01/23/2006	4246
R790CP	12/23/2005	List of Medicare Telehealth Services	04/03/2006	4204
R788CP	12/20/2005	Consultation Services (Codes 99241 – 99255)	01/17/2006	4215
R782CP	12/16/2005	Consultation Services (Codes 99241 – 99255) Rescinded and replaced by Transmittal 788	01/17/2005	4215
R775CP	12/02/2005	Home Care and Domiciliary Care Visits (99324 – 99350)	01/03/2006	4212
R748CP	11/04/2005	New G Code for Power Mobility Devices (PMDs)	10/25/2005	4121
R731CP	10/28/2005	Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215)	01/03/2006	4032
R713CP	10/18/2005	New G Code for Power Mobility Devices (PMDs)	10/25/2005	4121
R667CP	09/02/2005	Home Care and Domiciliary Care Visits (Codes 99321 - 99350)	12/05/2005	3922
R608CP	07/22/2005	New Health Professional Shortage Area (HPSA) Modifier	01/03/2006	3935

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R556CP	05/06/2005	Revision to the Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) Payment Rules	10/03/2005	3822
R547CP	04/29/2005	Revision to the Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) Payment Rules	10/03/2005	3822
R524CP	04/15/2005	Clarification to the Health Professional Shortage Area Language in the Medicare Claims Processing Manual	05/16/2005	3736
R517CP	04/01/2005	List of Medicare Telehealth Services	05/02/2005	3747
R504CP	03/11/2005	Update to Pub 100-04, Chapter 12, Section 200 of the Internet Only Manual	N/A	3732
R417CP	12/22/2004	Initial Preventive Physical Examination	01/03/2005	3638
R382CP	11/26/2004	Independent Laboratory Billing for the Technical Component (TC) of Physician Pathology Services to Hospital Patients	01/03/2005	3467
R302CP	09/24/2004	Nursing Facility Visits (Codes 99301 - 99313)	10/25/2004	3096
R280CP	08/13/2004	Billing and Payment in a Health Professional Shortage Area	10/04/2004	3401
R277CP	08/13/2004	Instructions to Establish Carrier Web Pages for Health Professional Shortage Area and for Provider Education for the HPSA and Physician Scarcity Area Bonus Payment	09/13/2004	3388
R218CP	06/25/2004	Implementation of the Analysis and Design Phases of The Revisions to the Health Professional Shortage Area Bonus Payment	10/04/2004	3317
R217CP	06/25/2004	Implementation of the Analysis and Design Phases of the Physician Scarcity Bonus	10/04/2004	3318

Rev #	Issue Date	Subject	Impl Date	CR#
R203CP	06/10/2004	Billing Payment in a Health Professional Shortage Area	07/06/2004	3336
R178CP	05/14/2004	Evaluation and Management Service Codes	N/A	2321
R168CP	05/07/2004	Chapter 12, Physician/Practitioner Billing0	N/A	1756
R157CP	04/30/2004	Implementation of the Analysis and Design Phase of the Physician Scarcity Bonus	10/04/2004	3223
R155CP	04/30/2004	Implementation of the Analysis and Design Phases of the Revision to the Health Professional Shortage Area Bonus Payment	10/04/2004	3215
R147CP	04/23/2004	Payment for Chemotherapy Administration Services, Nonchemotherapy Drug Infusion Services, and Drug Injection Services	05/24/2004	3192
R137CP	04/09/2004	Manualization of Section 4118 of the Medicare Carriers Manual, Part 3	N/A	3234
R078CP	02/06/2004	Medicare Incentive Payments for Physician Care	07/06/2004	3108
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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