

Medicare Carriers Manual Part 3 - Claims Process

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CHANGE REQUEST 1171

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
4830 - 4830 (Cont.)	4-573 - 4-574 (2 pp.)	4-573 - 4-574 (2pp.)
Table of Contents - Chapter V	5-2.1 - 5-2.2 (2 pp.)	5-2.1 - 5-2.2 (2 pp.)
5205	5-41 (1 p.)	5-41 - 5-42 (2 pp.)
Table of Contents - Chapter XV	15-1 - 15-2 (2 pp.)	15-1 - 15-2 (2 pp.)
15004 - 15008	15-3 - 15-6 (5 pp.)	15-3 - 15-6 (4 pp.)
15018 (Cont.) - 15018 (Cont.)	15-13 - 15-16 (4 pp.)	15-13 - 15-16 (4 pp.)
15033 - 15040	15-40.1 - 15-42 (3 pp.)	15-40.1 - 15-42 (3 pp.)
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15509.1 - 15511.1 (Cont.)	15-88.1-15-88.3 (3 pp.)	15-88.1 (1 p.)
15511.1 (Cont.) - 15511.1 (Cont.)	15-89 - 15-90 (2 pp.)	15-89-15-90 (2 pp.)
15515	15-93 (1 p.)	15-93 (1 p.)
Appendix A	A1 - A2 (2 pp.)	A1 - A2 (2 pp.)
16002 (Cont.) - 16003	16-7 - 16-8 (2 pp.)	16-7 - 16-8 (2 pp.)

CHANGED IMPLEMENTING INSTRUCTIONS--*EFFECTIVE DATE: January 1, 2000.*

IMPLEMENTATION DATE: January 1, 2001.

Claims previously adjudicated are unaffected.

Section 4830, Claims for Anesthesia Services Performed On and After January 1, 1992, is being revised to include the anesthesia modifier to be reported for a single medically directed certified registered nurse anesthetist case that was included in Program Memorandum (PM) B-98-2.

Section 5208, Payment for Certain Foot Surgery Procedures, and For Serial Surgery, has been **deleted**.

Section 15004, Entities/Suppliers Whose Physicians' Services Are Paid for Under Fee Schedule, is being revised to include Physician Assistants.

Section 15006, Method for Computing Fee Schedule Amount, reflects the conversion factor for year 2000, and the methods for computing payment amounts for 2000 through 2002.

Section 15018, Payment Conditions for Anesthesiology Services, is revised to incorporate the policy in PM B-98-2, as well as the policy on discontinuous anesthesia time published in the final physician fee schedule regulation published in the Federal Register on November 2, 1999. Furthermore, this section has been revised to conform to the language found in the provisions of regulation 42 CFR 414.46.

Section 15033, Assisted Suicide, is being added to exclude Medicare payment expenses for any health care service or health benefit coverage for the purpose of causing, or assisting to cause, the death of any individual.

Section 15036, Site-of-Service Payment Differential, has been revised to clarify the site-of-service policy for non-facility and facility settings.

Section 15039, Optometry Services, is being added to reflect the OBRA 1986 expanded coverage for optometrist services.

Section 15055, Allowable Adjustments, is being added to reflect the use of CPT 69990 (surgical operating microscope) instead of Modifier -20. Only those codes listed in this section may be paid separately when submitted with CPT 69990.

Section 15501, Evaluation and Management Service Codes - General (Codes 99201 - 99499), is revised to clarify how a physician submits a bill to reflect the service actually provided when less than the code requirement has been met. This section is also revised to clarify how physicians in a group practice should submit claims when more than one evaluation and management service is provided to the same patient on the same day by group members of the same specialty.

Section 15502, Payment for Office/Outpatient Visits (Codes 99201 - 99215), is revised to clarify that the professional component of a previous procedure does not impact the designation of a new patient status and an established one when billing an initial evaluation and management service.

Section 15506, Consultations (Codes 99241 - 99275), is revised to clarify that consultations may be based on the time spent in a face-to-face encounter in addition to the consultation requirements. This revision also clarifies that limited licensed practitioners may request consultations and provide other services within their State scope of practice in conjunction with applicable collaboration, general supervision and billing requirements. A cross-reference to §15501.H has also been added.

Section 15509.1, Payment For Physician's Visits To Residents of Skilled Nursing Facilities and Nursing Facilities, is revised to clarify payment requirements for federally mandated visits and all medically necessary visits. This change also discusses requirements for medically complex care visits provided by non-physician practitioners. Also discusses claims for unreasonable numbers of services to a number of residents within a 24-hour period.

Section 15510, Home Care and Domiciliary Care Visits (Codes 99321 - 99353), is revised to give the correct codes to use when a physician visits patients in a private residence, a domiciliary rest home, nursing facility, or a skilled nursing facility.

Section 15511.1, Prolonged Services (Codes 99354 - 99355), is revised to delete CPT code 99211 from the table.

Section 15515, Home Services (Codes 99341 - 99350), is revised to clarify that the medical record must state why a home visit is provided in lieu of an office or outpatient visit.

Appendix A-1999/2000, Geographic Practice Cost Indices by Medicare Carrier and Locality, is revised to give locality changes for 1999/2000.

Section 16002, Determining Reasonable Charges for Services of Nurse Practitioners and Clinical Nurse Specialists, is revised to delete "Visits to a Nursing Facility."

These instructions should be implemented within your current operating budget.

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

- 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 you receive a bill for an assistant surgeon following payment for co-surgeons or team surgeons, pay for the assistant only if a review of the claim verifies medical necessity.

4830. CLAIMS FOR ANESTHESIA SERVICES PERFORMED ON AND AFTER JANUARY 1, 1992

A. Billing Instructions.--Instruct providers to use the following modifiers when billing for anesthesia services:

- “-AA” - Physician personally performed.
- “-QK” - Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
- “-AD” - Medically supervised by a physician for more than four concurrent procedures.

- “-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.

NOTE: For service performed prior to January 1, 1994, the following modifiers should be used in place of modifier “-QK”:

- “-QJ” - Two concurrent procedures, medically directed by physician.
- “-QO” - Three concurrent procedures, medically directed by physician.
- “-QQ” - Four concurrent procedures, medically directed by physician.

Inform providers that the modifier for monitored anesthesia care (QS) is for informational purposes. Instruct providers to report actual anesthesia time on the claim form.

B. Claims Processing Requirements.--Determine payment for anesthesia services in accordance with §15018. You 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. You must also be able to determine the number of anesthesia time units from actual anesthesia time reported on the claim, differentiating 15 minute time unit intervals for personally performed anesthesia procedures and 30 minute time unit intervals for medically directed procedures. Multiply allowable units by the anesthesia-specific conversion factor used to determine fee schedule payment for the payment area.

C. Payment for Anesthesia for Multiple Surgeries.--Payment may be made for the anesthesia services provided during multiple or bilateral surgery sessions. See §15018.E for discussion of the payment rules for anesthesia to patients who undergo multiple, concurrent surgical procedures. See §§4826-4827 for a definition and appropriate billing and claims processing instructions for multiple and bilateral surgeries.

D. Billing for Anesthesia for Multiple Surgeries.--Instruct physicians, when billing for the anesthesia services associated with multiple or bilateral surgeries, to report the anesthesia procedure with the highest base unit value with the multiple procedures modifier “-51.” Report the total time for all procedures in the line item with the highest base unit value.

If the same anesthesia CPT-4 code applies to two or more of the surgical procedures, have billers enter the anesthesia code with the “-51” modifier and the number of surgeries to which the modified CPT-4 code applies.

Price multiple anesthesia services using the base unit of the anesthesia procedure with the highest base unit value and the actual time that extends over all procedures.

4831. BILLING FOR PORTABLE X-RAY SET-UP SERVICES

Instruct approved suppliers of portable x-ray services to use code “Q0092” when billing for set-up costs when the equipment is used in a home or nursing facility. The code is payable with each individual radiological code billed. It is not payable in connection with EKG services. Also, provide local instructions on billing for transportation costs associated with these services. Price the transportation costs locally.

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5205. CHARGES FOR RARE OR UNUSUAL PROCEDURES

You will occasionally be confronted with situations in which a new or rare procedure is performed and for which it is difficult to obtain information on customary and prevailing charges. In such situations, in order to make the reasonable charge determination, (a) obtain data, if possible, on the charges made for the unusual or rare procedure in other areas similar to the locality in which the service was rendered; or (b) consult with the local medical society regarding the appropriate charge to be made for this procedure. A relative value scale may be used together with available information about the physician's customary charges and about the prevailing charges for more frequently performed services in the locality in order to fill gaps in the data available to you. Where you cannot obtain sufficient information through your knowledge of medical care charges in other localities, consult with any medical authority that you would consider helpful, such as the medical personnel on your staff, the local or State medical society, or hospital medical personnel. In assessing the value of the procedure, the medical personnel should take into consideration: (a) its complexity; (b) the surgical skill required; (c) the time needed to perform the procedure; and (d) the prevailing charges in the locality for other procedures of comparable complexity. You should then base your judgment as to the reasonable charge for a given service on the best available medical opinion and information on customary and prevailing charges.

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15000. SCHEDULE FOR PHYSICIANS' SERVICES

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

15002. PHYSICIANS' SERVICES PAID UNDER FEE SCHEDULE

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

- Professional services (including attending physicians' services furnished in teaching settings) of doctors of medicine and osteopathy (including osteopathic practitioners), doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, and chiropractors;
- Supplies and services covered incident to physicians' services other than certain drugs covered as incident to services;
- Physical and occupational therapy furnished by physical therapists and occupational therapists in independent practices;
- Diagnostic tests other than clinical laboratory tests. See §5114 for payment for clinical diagnostic laboratory tests;
- Radiology services; and
- Monthly capitation payment (MCP) for physicians' services associated with the continuing medical management of end stage renal disease (ESRD) services.

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

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

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

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

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

- A privately practicing physical therapist, including a speech-language pathologist (for outpatient physical therapy and speech-language services),
- A privately practicing occupational therapist (for outpatient occupational therapy services),
- **A non-physician practitioner including a nurse practitioner, a physician assistant and a clinical nurse specialist beginning January 1, 1998, with respect to services these practitioners are authorized to furnish under state law.**
- Another entity that furnishes outpatient physical therapy, occupational therapy, and speech-language pathology services: namely, a rehabilitation agency, a public health agency, a clinic, a skilled nursing facility, a home health agency (for beneficiaries who are not eligible for home health benefits because they are not home bound beneficiaries entitled to home health benefits), hospitals (when such services are provided to an outpatient or to a hospital inpatient who is entitled to benefits under Part A but who has exhausted benefits during a spell of illness, or who is not entitled to Part A benefits) and comprehensive outpatient rehabilitation facilities (CORFs). The fee schedule also applies to outpatient rehabilitation services furnished under an arrangement with any of the enumerated entities that are to be paid on the basis of the physician fee schedule.
- The supplier of the technical component of any radiology or diagnostic service, or
- An independent laboratory doing anatomic pathology services.

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

15006. METHOD FOR COMPUTING FEE SCHEDULE AMOUNT

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

$$\text{Fee Schedule Amount} = [(\text{RVUw} \times \text{GPCIw}) + (\text{RVUpe} \times \text{GPCIpe}) + (\text{RVUm} \times \text{GPCIm})] \times \text{CF}$$

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

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

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

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

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

<p>2000 \$36.6137</p> <p>1997 \$40.9603(Surgical) \$33.8454(Non Surgical) \$35.7671(Primary Care)</p>	<p>1999 \$34.7315</p> <p>1995 \$39.447(S) \$34.616(NS) \$36.382 (PC)</p>	<p>1998 \$36.6873</p> <p>1993 \$31.962(S) \$31.249(NS)</p>
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1996	\$40.7986(S) \$34.6293(NS) \$35.4173(PC)	1994	\$35.158(S) \$32.905(NS) \$33.718(PC)	1992	\$31.001
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For the years 1999 through 2002, payment attributable to practice expenses will transition from charge-based amounts to resource-based practice expense RVUs. The practice expense RVUs calculated by HCFA reflect the following transition formula:

- 1999 - 75 percent of charged-based RVUs and 25 percent of the resource-based RVUs.
- 2000 - 50 percent of the charge-base RVUs and 50 percent of the resource-based RVUs.
- 2001 - 25 percent of the charge-based RVUs and 75 percent of the resource-based RVUs.
- 2002 - 100 percent of the resource-based RVUs.

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

Example of Computation of Fee Schedule Amount

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

$$\begin{aligned}\text{Work RVU (RVU}_w) &= 0.81 \\ \text{Practice expense RVU (RVU}_{pe}) &= 0.51 \\ \text{Malpractice RVU (RVU}_m) &= 0.04\end{aligned}$$

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

$$\begin{aligned}\text{Work GPCI (GPCI}_w) &= 0.994 \\ \text{Practice expense GPCI (GPCI}_{pe}) &= 0.912 \\ \text{Malpractice GPCI (GPCI}_m) &= 0.927\end{aligned}$$

Finally, using \$40.7986 as the uniform national CF, place the values into the formula provided and compute:

$$\begin{aligned}\text{Payment} &= (\text{RVU}_w \times \text{GPCI}_w) + (\text{RVU}_{pe} \times \text{GPCI}_{pe}) + (\text{RVU}_m \times \text{GPCI}_m) \times \text{CF} \\ \text{Payment} &= (0.81 \times 0.994) + (0.51 \times 0.912) + (0.04 \times .927) \times 40.7986 \\ \text{Payment} &= (0.81) + (0.47) + (0.04) \times 40.7986 \\ \text{Payment} &= (1.32) \times 40.7986 \\ \text{Payment} &= \$53.85 \text{ (Full Fee Schedule Payment)}\end{aligned}$$

Round fee schedule amounts to the nearest cent.

HCFA is providing you the essential components of the fee schedule, including the calculation of the fee schedule payment amounts for each locality, via the Medicare Fee Schedule Data Base.

B. No HCFA RVUs.--The only services for which HCFA does not give you relative values are:

- Those with local codes,
- Those with national codes where national relative values have not been established,
- Those requiring "By Report" payment or carrier pricing, and
- Those which are not included in the definition of physicians' services.

For services with national codes but for which national relative values have not been provided, establish local relative values (to be multiplied, in your system, by the national CF), as appropriate, or establish a flat local payment amount, whichever you prefer.

The "By Report" services (with national codes or modifiers) include services with codes ending in 99, team surgery services, unusual services, reduced services, and radio nuclide codes A4641 and 79900. The status indicators of the Medicare Fee Schedule Data Base identify these specific national codes and modifiers that you are to continue to pay for on a "By Report" basis. Do not establish RVUs for them. Similarly, do not establish RVUs for "By Report" services with local codes or modifiers.

Do not establish RVUs for noncovered and always bundled services for which HCFA has not established national RVUs. The Medicare fee schedule data base identifies noncovered national codes and codes which are always bundled.

C. 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 determination of which HCPCS codes fall into this category is made by HCFA.

D. No Special RVUs for Limited License Practitioners.--There are no special RVUs for limited license physicians, e.g., optometrists, 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.

If a physician bills a visit on the same day that he or she also bills for physical therapy using CPT physical therapist codes, the physician must be prepared to document that the visit was unrelated to the physical therapy services for which separate payment is made.

Physicians and independently practicing physical therapists may bill for physical therapy modalities and therapies using the CPT codes (97010-97799). Do not restrict their use of these codes other than to ensure that duplicate payment is not made for services on the same date of service. For example, you may not restrict either physicians or independently practicing physical therapists to use of the alpha-numeric codes. Pay the same amount for a code regardless of whether an independently practicing physical therapist or a physician bills it.

15008. TRANSITION PAYMENTS

The fee schedule amounts computed above apply in 1996 if there is no transition to the fee schedule for that particular code in that area. The transition occurred from 1992 through 1995. To determine whether the transition provisions apply, the historical payment basis for a service is compared to the fee schedule amount computed under §15006. The results are transition fee schedule amounts applicable in 1992 through 1995.

15010. BUNDLED SERVICES/SUPPLIES

There are a number of services/supplies which are covered under Medicare and which have CPT codes, but they are services for which Medicare bundles payment into the payment for other related services.

A. Routinely Bundled.--These are services/supplies for which separate payment is almost never made. HCFA has provided RVUs for many of the bundled services/supplies. However, the RVUs are not for Medicare payment use. Do not establish your own relative values for these services.

If you receive a claim which is solely for one of these always bundled services or supplies, develop the claim. If the physician has, at any time in the past year, rendered another service to the beneficiary, consider the bill for the service/supply part of or incident to that prior service. If the physician has not provided another service to the patient during that time period, use RVUs, if provided, as a guide for payment, for any service which is the subject of the claim on a "By Report" basis if it qualifies as a covered physician service. However, deny payment for any service/supply item which is the sole subject of the claim, since there is no service to which it can be incident.

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. Pay separately for those injection services only if

anesthesia if the surgeon also performs the surgical procedure. Similarly, separate payment is not allowed for the psychiatrist's performance of the anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs the electroconvulsive therapy.

B. Payment at Personally Performed Rate.--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; or
- The physician is involved with one anesthesia case with an intern or resident, the physician is the teaching physician as defined in MCM §15016, and the service is furnished on or after January 1, 1996; or
- The physician is continuously involved in a single case involving a student nurse anesthetist; or
- 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, you may pay the physician service and the CRNA (or AA) service pursuant to the medical direction payment policy in MCM §15018.
- 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 would report using the "AA" modifier and the CRNA would use the "QZ" modifier for a nonmedically directed case.

C. Payment at the Medically Directed Rate.--Determine payment for the physician's medical direction service furnished on or after January 1, 1998 on the basis of 50 percent of the allowance for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified individuals in two, three or four concurrent cases and the physician performs the activities described as follows:

- 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;
- Provides indicated-post-anesthesia care.

The requirement that the physician participate in the most demanding procedures of the anesthesia plan, including induction and emergence, was included at a time when general anesthesia was the usual mode of practice for anesthesia services. However, since that time other types of anesthesia care, such as regional anesthetics and monitored anesthesia care, have become more common. 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. 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 exam and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and 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 another involving a CRNA, AA, intern or resident.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who rendered 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. Do not make payment under the fee schedule.

See subsection J for a definition of concurrent anesthesia procedures.

D. Payment at Medically Supervised Rate.--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 can be recognized if the physician can document he or she was present at induction.

E. Payment for Multiple Anesthesia Procedures.--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.

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 §§4630 and 15068) 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 means the time 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 is reported on the claim. For anesthesia services furnished on or after January 1, 1994, compute time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place. Do not recognize time units for 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.--Pay for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services. Instruct anesthesiologists to use modifier QS to report monitored anesthesia care cases. Monitored anesthesia care involves the intraoperative 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 post-operative 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 are furnished after January 1, 1992. 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.

<u>Procedure</u>	<u>Number of Concurrent Medically Directed Procedures</u>	<u>Base Unit Reduction Percentage</u>
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.---Instruct the physician to use the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised. See MCM §4830 for billing instructions for anesthesia services and modifiers.

15030. SUPPLIES

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

A. HCPCS codes A4550, A4200, and A4263 are billed in conjunction with the appropriate procedure in the Medicare Physician Fee Schedule Data Base (place of service is physician's office); or

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). The procedures performed are:

- Diagnostic radiologic procedures (including diagnostic nuclear medicine) requiring pharmaceutical or radiopharmaceutical contrast media and/or pharmacological stressing agent,
- Other diagnostic tests requiring a pharmacological stressing agent,
- Clinical brachytherapy procedures (other than remote afterloading 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.

15032. PARTICIPATING VERSUS NONPARTICIPATING DIFFERENTIAL

For services/supplies rendered prior to January 1, 1994, payments to nonparticipating physicians, under the fee schedule, may not exceed 95 percent of the 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 cannot exceed 95 percent of the fee schedule amount.

For services/supplies rendered on or after January 1, 1994, and for which payment is or could be made under the physician fee schedule, payments to any non-participant may not exceed 95 percent of the fee schedule amount or other payment basis for the service/supply. Effective for services rendered on or after January 1, 1994, the 5 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 5 percent reduction not only when they bill for services paid for under the physician fee schedule, but also when they bill for services for which the law permits physician fee schedule payment, but for which the Secretary has established an alternative payment method. The services/supplies included in this latter category, as of January 1, 1994, 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. Therefore, the Medicare payment allowance for "incident to" drugs and biologicals billed by any nonparticipant cannot exceed 95 percent of whichever is lower, the AWP or the estimated acquisition cost.

15033. ASSISTED SUICIDE

The Assisted Suicide Funding Act of 1997 prohibits the use of Federal funds to furnish or pay for any health care service or health benefit coverage for the purpose of causing, or assisting to cause, the death of an individual. Such a service is excluded from coverage; therefore, no payment may be made.

15036. SITE-OF-SERVICE PAYMENT DIFFERENTIAL

Under the physician fee schedule, separate practice expense relative value units (PERVUs) are calculated for procedures furnished in facility and in non-facility settings. Facility PERVUs are applicable to procedures (except for therapy procedures) furnished:

- In hospitals;
- To patients in a Part A stay in a skilled nursing facility (SNF) identified on the HCFA 1500 claim form indicating Place of Service (POS) code 31; and
- In an ambulatory surgical center (ASC) that are included on the ASC approved list of procedures.

Non-facility PERVUs are applicable to procedures furnished:

- To patients who are not in a Part A stay in a SNF identified on the HCFA 1500 claim form indicating place of service (POS) code 32;
- In an ASC that is not included on the ASC approved list of procedures; and
- In all other facilities.

Non-facility PERVUs are applicable to therapy procedures regardless of whether they are furnished in facility or non-facility settings.

15038. MULTIPLE SURGERIES (CPT MODIFIER 51)

A. **General.**--When more than one surgical service is performed on the same patient, by the same physician, and on the same day:

- The fee schedule amount for a second procedure is 50 percent of the fee schedule amount that would have been otherwise applicable for that procedure; and
- The fee schedule amount for the third through fifth procedures is 50 percent of the fee schedule amount that would have been otherwise applicable for that procedure. Prior to January 1, 1995, the third through fifth procedures were paid at 25 percent of the fee schedule amount. Surgical procedures beyond the fifth are priced "by report" based on documentation of the services furnished. (See §4826.C for systems requirements related to payment for multiple surgeries.)

Sequence the procedures from the one which has the highest regular fee schedule amount to the one with the lowest. In the case of interventional radiology procedures, see §15022.E.

B. **Multiple Endoscopies.**--For multiple endoscopic procedures, use the full value of the highest valued endoscopy plus the difference between the next highest and the base endoscopy. For example, in the course of performing a fiberoptic colonoscopy (code 45378), a physician performs a biopsy (code 45380) and removes a polyp (code 45385). Both codes 45380 and 45385 contain the values of the base endoscopy, code 45378. Use the actual value of code 45385 plus the difference between codes 45380 and 45378. The endoscopic base codes are listed in the MFSDB. (See §4826.C.12 for additional information.)

15039. OPTOMETRY SERVICES

Effective April 1, 1987, Medicare pays for services of an optometrist, acting within the scope of his or her license, if he or she furnishes services that would be covered as physicians' services when performed by a doctor of medicine or osteopathy. To be covered under Medicare, the services must be medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all other applicable coverage requirements. (See also §§2020.5 and 5250.)

15040. BILATERAL SURGERY

15040.1 General.--Make the reductions discussed in this section to subsequent bilateral surgical procedures performed by the same physician on the same day. See §4827 for systems requirements related to payment for bilateral procedures.

15040.2 Bilateral Surgery Indicators.--Use the bilateral surgery indicator in the fee schedule data base shown for each code which indicates whether the bilateral surgery reduction policy applies to the code.

A. Bilateral Surgery Indicator Equals 0.--The bilateral adjustment is inappropriate for codes with indicator 0 because of physiology or anatomy or because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

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

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

Some codes related to eyelids and/or eyelashes have a bilateral indicator of "0" but a multiple surgery indicator of "1" (standard or revised standard multiple surgery codes apply). (See §15038.) These codes may be provided as double bilaterals for which the physician bills as many units of the code as the number of procedures performed. For example, the physician bills for 4 units of the code if he or she performs the procedure on the top and bottom lid of each eye. You would then apply the multiple surgery rules in §15038 to the 4 units billed.

B. Bilateral Surgery Indicator Equals 1.--The bilateral adjustment is appropriate for codes with bilateral indicator of 1 because the code description is for a unilateral service and the payment amount is for a unilateral service, but physiology permits the service to be performed bilaterally.

Base payment on the lower of (a) the total actual charge for both sides or (b) 150 percent of the fee schedule payment for a single code if the code is billed with the bilateral modifier (CPT modifier -50) or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field).

EXAMPLE: The fee schedule amount for code BBBBB is \$125. The physician reports code BBBBB-LT and BBBBB-RT with an actual charge of \$100 for each code. Base payment on \$187.50 (150 percent of the fee schedule amount for one code of \$125) because it is lower than the actual charges for the left and right sides (\$200). If the code is reported as a bilateral procedure and is reported with other

15052. HPSA BONUS PAYMENTS

In HPSA areas, pay physicians an additional 10 percent above the amount paid under the fee schedule (i.e., 10 percent of 80 percent of the lower of the fee schedule or the actual charge). See §3350 for detailed instructions.

15054. NO ADJUSTMENTS

Do not make fee schedule adjustments for:

- Inherent reasonableness (see §5246);
- Comparability (see §5026);
- Multiple visits to nursing homes (i.e., when more than one patient is seen during the same trip) (see §5210);
- Refractions. If you receive a claim for a service that also indicates that a refraction was done, do not reduce payment for the service. HCFA has already made the reduction in the RVUs being provided to you. See §§4125 and 5217 for claims processing instructions;
- HCPCS alpha-numeric modifiers AT (acute treatment), ET (emergency treatment), LT (left side of body), RT (right side of body), SF (second opinion ordered by PRO), YY (second surgical opinion), and ZZ (third surgical opinion);
- 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).

15055. ALLOWABLE ADJUSTMENTS

Effective 1/1/2000, the replacement code (CPT 69990) for modifier -20, 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 64870, 64885 through 64898 and 64905 through 64907.

15056. MULTIPLE ADJUSTMENTS

When multiple adjustments apply, see billing guidelines beginning at §4826 for the sequence.

15058. UPDATE FACTOR FOR FEE SCHEDULE SERVICES

HCFA provides, on an annual basis, an update factor which you are to apply to update fee schedule amounts. (See §15006.)

Pay for all services rendered in 1992 on the basis of the 1992 fee schedule amounts and for all services rendered prior to 1992 on the basis of the 1991 screens. In processing fee schedule claims in 1993 and beyond, apply the fee schedule screen in effect on the date the service was rendered. However, maintain in your system no more than two update or payment periods, i.e., maintain in your system only the current fee schedule screens and the prior year screens. Therefore, if a service was rendered prior to the date that the prior year screens were in effect, and the claim is only just being processed, pay based on the prior year screen. Note that this seldom, if ever, occurs now that physicians and suppliers are required to submit unassigned claims within 12 months of providing a service.

15360. ECHOCARDIOGRAPHY SERVICES (CODES 93303 - 93350)

Separate Payment for Contrast Media.--Effective October 1, 2000, physicians may separately bill for contrast agents used in echocardiography. Physicians should use HCPCS Code Q0188 (Supply of injectable contrast material for use in echocardiography, per study). The type of service code is 9. This code will be carrier-priced.

15400. CHEMOTHERAPY ADMINISTRATION (CODES 96400-96549)

A. General Use of Codes.--Chemotherapy administration codes, 96400 through 96450, 96542, 96545, and 96549, are only to be used when reporting chemotherapy administration when the drug being used is an antineoplastic and the diagnosis is cancer. The administration of other drugs, such as growth factors, saline, and diuretics, to patients with cancer, or the administration of antineoplastics to patients with a diagnosis other than cancer, are reported with codes 90780 through 90784 as appropriate.

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

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

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

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

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

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

A. Use Of CPT Codes.--Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

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

The physician must have provided all the services necessary to meet the CPT description of the level of service billed. A claim for a service must reflect the service actually performed. A physician may submit a claim for CPT code 99499, Unlisted evaluation and management service with a detailed report stating why the visit was medically necessary and describing what service(s) was performed. The carrier has the discretion in valuing the service when the service does not meet the terms of the CPT description (e.g., only a history is performed). 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. }tc \l2 "C. Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling. }--Advise physicians that when counseling and/or coordination of care dominates (more than 50%) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

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

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

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

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

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

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

E. Billing For Medically Necessary Visit On Same Occasion As Preventive Medicine Service.--When a physician furnishes a Medicare beneficiary a covered visit, at the same place and on the same occasion as a 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 non-covered 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 on the basis of 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 non-covered 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.

F. Payment for Immunosuppressive Therapy.--Advise physicians to 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. The payment limit that was applied to transplant surgeons (see §5020.4.E.) is not applicable for services furnished after December 31, 1991.

G. Services Furnished Incident To Physician's Service By Nonphysician Practitioners.--Advise physicians that when evaluation and management services are furnished incident to a physician's service by a nonphysician practitioner who meets the criteria in §§2154, 2156, 2158, or

2160, 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, and the employee does not meet the criteria in §§2154, 2156, 2158, or 2160, 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 (see §§2050.1, 2050.2) and are medically necessary for the individual needs of the patient.

H. Physicians In Group Practice.--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. (Refer to §15511, Prolonged Services, when the duration of the direct face-to-face contact between the physician and the patient exceeds the typical time of the visit code billed.)

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.

15501.1 Payment For Evaluation and Management Services Provided During Global Period Of Surgery.--

A. CPT Modifier 24-Unrelated Evaluation and Management Service By Same Physician During Post-operative Period.--Pay for an evaluation and management service other than inpatient hospital care before discharge from the hospital following surgery (CPT codes 99221-99238) which was provided during the post-operative period of a surgical procedure when it is furnished by the same physician who performed the procedure if it was billed with CPT modifier 24 and is accompanied by documentation that supports that the service is not related to the postoperative care of the procedure. Do not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred. 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.--Pay for an evaluation and management service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable evaluation and management service that is above and beyond the pre- and post-operative work of the procedure.

If the physician bills the service with the CPT modifier 25, 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, 90337, 90945, and 90947), the physician must document that the service was unrelated to the dialysis and could not be performed during the dialysis procedure;

- When pre-operative 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 (see §15508.G.); 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 pre-payment screens or documentation requirements for that provider or group.

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

15502. PAYMENT FOR OFFICE/OUTPATIENT VISITS (CODES 99201-99215)

A. Definition of New Patient For Selection Of Visit Code.--Interpret the phrase "new patient" to mean a patient who has not received any professional services from the physician within the previous 3 years. (See definition of physicians in group practice in Section 15501H.)

If no evaluation and management service is performed, the patient may continue to be treated as a new patient. For example, if a professional component of a previous procedure is billed in a 3-year time-period, e.g., a lab interpretation is billed and no evaluation and management service is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an evaluation and management service does not affect the designation of a new patient .

B. Office/Outpatient Visits Provided On Same Day For Unrelated Problems.--Do not pay two office visits billed by a physician for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office or outpatient setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed 5 hours later by a visit for evaluation of leg pain following an accident).

C. Office/Outpatient or Emergency Department Visit On Day Of Admission To Nursing Facility.--Do not pay a physician for an emergency department visit or an office visit and a comprehensive nursing facility assessment on the same day. Bundle evaluation and management services on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician. (See §15509.)

D. Injection and Evaluation and Management Code Billed Separately on Same Day of Service.--Advise physicians that CPT code 99211 cannot be used to report a visit solely for the purpose of receiving an injection which meets the definition of CPT codes 90782, 90783, 90784, or 90788. Do not pay CPT codes 90782, 90783, 90784, or 90788 if any other physician fee schedule service was rendered.

The drug is billed as a J code, whether the injection is separately billable or not.

If no evaluation and management service or other service is provided on the same day as the injection, the injection code is billed.

15504. PAYMENT FOR HOSPITAL OBSERVATION SERVICES (CODES 99217-99220)

A. Who May Bill Initial Observation Care.--Pay for initial observation care billed by only the physician who admitted the patient to hospital observation and was responsible for the patient during his/her stay in observation. A physician who does not have inpatient admitting privileges but who is authorized to admit a patient to observation status may bill these codes.

For a physician to bill the initial observation care codes, there must be a medical observation record for the patient which contains dated and timed physician's admitting orders regarding the care the patient is to receive while in observation, nursing notes, and progress notes prepared by the physician while the patient was in observation status. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.

Payment for an initial observation care code is for all the care rendered by the admitting physician on the date the patient was admitted to observation. All other physicians who see the patient while he or she is in observation must bill the office and other outpatient service codes or outpatient consultation codes as appropriate when they provide services to the patient.

For example, if an internist admits a patient to observation and asks an allergist for a consultation on the patient's condition, only the internist may bill the initial observation care code. The allergist must bill using the outpatient consultation code that best represents the services he or she provided. The allergist cannot bill an inpatient consultation since the patient was not a hospital inpatient.

B. Physician Billing For Observation Care Following Admission To Observation.--If the patient is discharged on the same date as admission to observation, pay only the initial observation care code because that code represents a full day of care.

If the patient remains in observation after the first date following the admission to observation, it is expected that the patient would be discharged on that second calendar date. The physician bills CPT code 99217 for observation care discharge services provided on the second date.

In the rare circumstance when a patient is held in observation status for more than two calendar dates, the physician must bill subsequent services furnished before the date of discharge using the outpatient/office visit codes. The physician may not use the subsequent hospital care codes since the patient is not an inpatient of the hospital.

C. Admission To Inpatient Status From Observation.--If the same physician who admitted a patient to observation status also admits the patient to inpatient status from observation before the end of the date on which the patient was admitted to observation, pay only an initial hospital visit for the evaluation and management services provided on that date. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill an initial observation care code for services on the date that he or she admits the patient to inpatient status. If the patient is admitted to inpatient status from observation subsequent to the date of admission to observation, the physician must bill an initial hospital visit for the services provided on that date. The physician may not bill the hospital observation discharge management code (code 99217) or an outpatient/office visit for the care provided in observation on the date of admission to inpatient status.

D. Hospital Observation During Global Surgical Period.--The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, and 99220) services unless the criteria for use of CPT modifiers 24, 25, or 57 are met. Pay for these services in addition to the global surgical fee only if both of the following requirements are met:

D. Transfer From One Hospital To Another By Same Physician; 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.--Advise physicians that they may bill both the hospital discharge management code and an initial hospital care code when the discharge and admission do not occur on the same day if the transfer is between (1) different hospitals, (2) different facilities under common ownership which do not have merged records, or (3) between the acute care hospital and a PPS exempt unit within the same hospital when there are no merged records.

In all other transfer circumstances, the physician should bill only the appropriate level of subsequent hospital care for the date of transfer.

E. Initial Hospital Care Service History and Physical That Is Less Than Comprehensive.--Advise physicians that when a physician performs a visit or consultation that meets the definition of a level 5 office visit or consultation several days prior to an admission and then on the day of admission performs less than a comprehensive history and physical, he or she should report the office visit or consultation that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code 99221) for the initial hospital admission. Pay the office visit as billed and the level 1 initial hospital care code.

F. Initial Hospital Care Visits by Two Different M.D.s or D.O.s When They Are Involved in Same Admission.--Advise physicians to use the initial hospital care codes (codes 99221-99223) to report the first hospital inpatient encounter with the patient when he or she is the admitting physician.

Consider only one M.D. or D.O. to be the admitting physician and permit only the admitting physician to use the initial hospital care codes. Advise physicians that if they participate in the care of a patient but are not the admitting physician of record, they should bill the inpatient evaluation and management services codes that describe their participation in the patient's care (i.e., subsequent hospital visit or inpatient consultation).

G. Initial Hospital Care and Nursing Facility Visit on Same Day.--Pay only the initial hospital care code if the patient is admitted to a hospital following a nursing facility visit on the same date by the same physician. Instruct physicians that they may not report a nursing facility service and an initial hospital care service on the same day. Payment for the initial hospital care service includes all work performed by the physician in all sites of service on that date.

15505.2 Subsequent Hospital Visit and Hospital Discharge Management (Codes 99231-99239).--

A. Subsequent Hospital Visit and Discharge Management on Same Day.--Pay only the hospital discharge management code on the day of discharge (unless it is also the day of admission, in which case, the admission service and not the discharge management service is billed). Do not pay both a subsequent hospital visit in addition to hospital discharge day management service on the same day by the same physician. Instruct physicians that they may not bill for both a hospital visit and hospital discharge management for the same date of service.

B. Hospital Discharge Management (CPT Codes 99238 and 99239) and Nursing Facility Admission Code When Patient Is Discharged From Hospital and Admitted To Nursing Facility on Same Day.--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 post-operative period of a service with the global surgical period, he/she bills for the nursing facility admission and care with a -24 modifier 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 5 years following discharge from the hospital for cholecystectomy).

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.

15506. CONSULTATIONS (Codes 99241 - 99275)

A. Consultation Versus Visit.--Pay for a consultation when all of the criteria for the use of a consultation code are met:

(1) Specifically, a consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (unless it is a patient-generated confirmatory consultation).

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

(3) After the consultation is provided, the consultant prepares a written report of his/her findings which is provided to the referring physician.

Consultations may be billed for time if the counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician and the patient. The preceding requirements must also be met.

B. Consultation Followed By Treatment.--Pay for an initial consultation if all the criteria for a consultation are satisfied. Payment may be made regardless of treatment initiation unless a transfer of care occurs. A transfer of care occurs when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance. The receiving physician would report a new or established patient visit depending on the situation (a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years) and setting (e.g., office or inpatient).

A physician consultant may initiate diagnostic and/or therapeutic services at an initial or subsequent visit. Subsequent visits (not performed to complete the initial consultation) to manage a portion or all of the patient's condition should be reported as established patient office visit or subsequent hospital care, depending on the setting.

C. Consultations Requested by Members of Same Group.--Pay for a consultation if one physician in a group practice requests a consultation from another physician in the same group practice as long as all of the requirements for use of the CPT consultation codes are met. (See §§15506A and 15501.H.)

Limited licensed practitioners, e.g., nurse practitioners or physician assistants, may request a consultation. They may perform other services within the scope of practice for limited licensed practitioners in the State in which they practice. Applicable collaboration and general supervision rules apply as well as billing rules.

D. Documentation For Consultations.--A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record. A written report must be furnished to the requesting physician.

In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the referring physician and the consultant, the request may be documented as part

of a plan written in the requesting physician's progress note, an order in the medical record, or a specific written request for the consultation. In these settings, the report may consist of an appropriate entry in the common medical record. In an office setting, the documentation requirement may be met by a specific written request for the consultation from the requesting physician or if the consultant's records show a specific reference to the request. In this setting, the consultation report is a separate document communicated to the requesting physician.

E. Consultation for Preoperative Clearance.--Pay for the appropriate consultation code for a pre-operative consultation for a new or established patient performed by any physician at the request of a surgeon, as long as all of the requirements for billing the consultation codes are met.

F. Post-Operative Care By Physician Who Did Pre-Operative Clearance Consultation.--Advise physicians that if, subsequent to the completion of a pre-operative consultation in the office or hospital, the consultant assumes responsibility for the management of a portion or all of the patient's condition(s) during the post-operative period, the consultation codes should not be used. In the hospital setting, the physician who has performed a pre-operative consultation and assumes responsibility for the management of a portion or all of the patient's condition(s) during the post-operative period should use the appropriate subsequent hospital care codes (not follow-up consultation codes) to bill for the concurrent care he or she is providing. In the office setting, the appropriate established patient visit code should be used during the post-operative period.

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

G. Surgeon's Request That Another Physician Participate In Post-Operative Care.--If the surgeon asks a physician who had not seen the patient for a pre-operative consultation to take responsibility for the management of an aspect of the patient's condition during the post-operative period, the physician may not bill a consultation because the surgeon is not asking the physician's opinion or advice for the surgeon's use in treating the patient. The physician's services would constitute concurrent care and should be billed using the appropriate level visit codes. See §15506 subsection F if the physician did a pre-operative clearance consultation.

H. Examples of Consultations--

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

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

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

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

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

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

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

I. Examples That Do Not Satisfy the Criteria for Consultations --

1. Standing orders in the medical record for consultations.
2. No order for a consultation.
3. No written report of a consultation

4. After hours, an internist receives a call from her patient about a complaint of abdominal pain. The internist believes this requires immediate evaluation and advises the patient to go to the emergency room where she meets the patient and evaluates him. The emergency room physician does not see the patient. The internist should bill for the appropriate level of emergency department service, or if the patient is admitted to the hospital she would bill this visit as an inpatient admission.

15509.1 Payment For Physician's Visits To Residents Of Skilled Nursing Facilities and Nursing Facilities.--

A. Visits to Perform Resident Assessments.--Pay for visits necessary to perform all Medicare required assessments. Physicians should use the CPT codes for comprehensive nursing facility assessments (99301-99303) to report evaluation and management services involving comprehensive resident assessments. Evaluation and Management documentation guidelines apply. (See §15510 for further clarification on use of SNF/NF codes.)

B. Visits to Comply With Federal Regulations (42 CFR 483.40).--Pay for visits required to monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. These visits and all other medically necessary visits for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are covered under Medicare Part B. Physicians should use CPT codes for subsequent nursing facility care (99311-99313) when reporting evaluation and management services that do not involve resident assessments. Medicare does not pay for additional visits required by State law for an admission unless the visits are necessary to meet the medical needs of the individual resident.

C. Medically Complex Care.--Pay for visits to residents in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are medically necessary and documented in the medical record. Physicians should use CPT codes for subsequent nursing facility care (99311-99313) when reporting evaluation and management services.

D. Visits by Non-Physician Practitioners.--Visits to comply with Federal Regulations (see 15509.1B) in SNFs after the initial visit by the physician may, at the option of the physician, be provided by a non-physician practitioner, i.e., physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS). (Refer to 42 CFR 483.40(4) and (e).)

Any medically necessary physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied, when performed by an NP, PA or CNS (at the option of the State) who is not an employee of the facility in which they practice. (Refer to 42 CFR 483.40 (f).)

Where a physician establishes an office in a SNF/NF, the "incident to" services and requirements are confined to this discrete part of the facility designated as his/her office. "Incident to" services may not be billed in an hospital setting. Thus, services performed outside the "office" area would be subject to the coverage rules applicable to services provided outside the office setting, i.e., nursing home. (Refer to CIM 45-15.)

Services provided by physician-employed or independent non-physician practitioners must meet Medicare requirements and fall within the scope of services that practitioners are licensed to perform. A physician assistant must be under the general supervision of the physician. These visits and all other medically necessary visits for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are covered under Medicare Part B.

E. Gang Visits.--Although the selection of the level of service for an evaluation and management encounter is not based on time, the CPT codes provide an approximate time typically spent with a resident. The level of service and code billed must be medically necessary (§§1862 (a)(1)(A) of the Social Security Act) for each resident. Claims for an unreasonable number of visits to residents at a facility within a 24-hour period may indicate an aberrancy and result in medical review to determine medical necessity. Medical records must document the specific services to each individual resident.

15510. HOME CARE AND DOMICILIARY CARE VISITS (CODES 99321-99353)

A. Physician Visits to Patients Residing in Various Places of Service.--Current Procedural Terminology (CPT) codes 99321 through 99333, domiciliary, rest home (e.g., boarding home), or custodial care services, are used to report evaluation and management (E/M) services to residents residing in a facility which provides room, board, and other personal assistance services, generally on a long-term basis. These codes are limited to the specific two digit places of service (POS) codes 32 (nursing home/nursing facility), 33 (custodial care facility), 55 (residential substance abuse facility), and 56 (psychiatric residential). These facilities, also often referred to as adult living facilities or assisted living facilities, do not have a medical component.

Physicians and providers furnishing E/M services to residents in a living arrangement described by one of the POS listed above must use the level of service code in the range of codes 99321- 99333 to support the service they provide.

CPT codes 99341 through 99350, home services codes, are used to report E/M services furnished to a patient residing in his or her own private residence and not any type of facility. These codes apply only to the specific two digit POS 12 (Patient's Home). Home Services codes, CPT codes 99341 through 99350, may not be used for billing for E/M services provided other than in the private residence of an individual.

E/M services provided to patients residing in a skilled nursing facility (SNF) (CPT definition formerly identified as SNFs, intermediate care facilities (ICFs), or long term care facilities (LTCFs) must be reported using the appropriate level of service code within the range identified for comprehensive nursing facility assessments and subsequent nursing facility care services. Codes range from 99301 through 99303 for the former and 99311 through 99313 for the latter, and Nursing Facility Discharge Services codes 99315 - 99316. These codes are limited to the specific two digit POS 31 (SNF) and 54 (ICF).

15511. PROLONGED SERVICES AND STANDBY SERVICES (CODES 99354-99360)

15511.1 Prolonged Services (Codes 99354 - 99355).--

A. Required Companion Codes.--Pay prolonged services codes 99354-99355 when they are billed on the same day by the same physician as the companion evaluation and management codes and:

- The companion codes for 99354 are 99201-99205, 99212-99215, or 99241-99245;
- The companion codes for 99355 are 99354 and one of the evaluation and management codes required for 99354 to be used;
- The companion codes for 99356 are 99221-99223, 99231-99233, 99251-99255, 99261-99263, 99301-99303, or 99311-99313; or
- The companion codes for 99357 are 99356 and one of the evaluation and management codes required for 99357 to be used.

Do not pay prolonged services codes 99354-99358 unless they are accompanied by one of these companion codes.

B. Requirement for Physician Presence.--Advise physicians to count only the duration of direct face-to-face contact between the physician and the patient (whether the service was continuous or not) beyond the typical time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable. In the case of prolonged office services, time spent by office staff with the patient, or time the patient remains unaccompanied in the office cannot be billed. In the case of prolonged hospital services, time spent waiting for test results, for changes in the patient's condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services.

C. Documentation.--Do not require documentation to accompany the bill for prolonged services unless the physician has been targeted for medical review. Advise physicians that to support billing for prolonged services, the medical record must document the duration and content of the evaluation and management code billed and that the physician have personally furnished at least 30 minutes of direct service after the typical time of the evaluation and management service had been exceeded by at least 30 minutes.

D. Use of the Codes.--Advise physicians that prolonged services codes can be billed only if the total duration of all physician direct face-to-face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician provided (typical time plus 30 minutes). If the total duration of direct face-to-face time does not equal or exceed the threshold time for the level of evaluation and management service the physician provided, the physician may not bill for prolonged services.

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E. Threshold Times for Codes 99354 and 99355.--If the total direct face-to-face time equals or exceeds the threshold time for code 99354, but is less than the threshold time for code 99355, the physician should bill the visit and code 99354. Do not accept more than 1 unit of code 99354. 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. Use the following threshold times to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office/outpatient visit and consultation codes.

<u>Code</u>	<u>Typical time for code</u>	<u>Threshold time to bill code 99354</u>	<u>Threshold time to bill codes 99354 and 99355</u>
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
99241	15	45	90
99242	30	60	105
99243	40	70	115
99244	60	90	135
99245	80	110	155

Add 30 minutes to the threshold time for billing codes 99354 and 99355 to get the threshold time for billing code 99354 and 2 units of code 99355. For example, to bill code 99354 and 2 units of code 99355 when billing a code 99205, the threshold time is 150 minutes.

F. Threshold Times for Codes 99356 and 99357.--If the total direct face-to-face time equals or exceeds the threshold time for code 99356, but is less than the threshold time for code 99357, the physician should bill the visit and code 99356. Do not accept more than 1 unit of code 99356. If the total direct face-to-face time equals or exceeds the threshold time for code 99356 by no more than 29 minutes, the physician bills the visit code 99356 and one unit of code 99357. One additional unit of code 99357 is billed for each additional increment of 30 minutes extended duration. Use the following threshold times to determine if the prolonged services codes 99356 and/or 99357 can be billed with the office/outpatient visit and consultation codes.

<u>Code</u>	<u>Threshold time for code</u>	<u>Threshold time to bill code 99356</u>	<u>Threshold time to bill codes 99356 and 99357</u>
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110

<u>Code</u>	<u>Typical time for code</u>	<u>Threshold time to bill code 99356</u>	<u>Threshold time to bill codes 99356 and 99357</u>
99251	20	50	95
99252	40	70	115
99253	55	85	130
99254	80	110	155
99255	110	140	185
99261	10	40	85
99262	20	50	95
99263	30	60	105
99301	30	60	105
99302	40	70	115
99303	50	80	125
99311	15	45	90
99312	25	55	100
99313	35	65	110

Add 30 minutes to the threshold time for billing codes 99356 and 99357 to get the threshold time for billing code 99356 and 2 units of 99357.

G. Examples of Billable Prolonged Services.--

1. A physician performed a visit that met the definition of visit code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills code 99213 and 1 unit of code 99354.

2. A physician performed a visit that met the definition of visit code 99303 and the total duration of the direct face-to-face contact (including the visit) was 115 minutes. The physician bills codes 99303, 99356, and 1 unit of code 99357.

H. Examples of Nonbillable Prolonged Services.--

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.

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.

15511.2 Prolonged Services Without Face-to-Face Service (Codes 99358-99359).--Do not pay prolonged services codes 99358 and 99359, which do not require any direct patient contact. Payment for these services is included in the payment for direct face to face services that physicians bill. The physician cannot bill the patient for these services since they are Medicare covered services and payment is included in the payment for other billable services.

D. Who May Bill.--Only the physician who has signed the patient's plan of care may be paid for HCPCS codes G0064 and G0065.

E. Documentation.--Advise physicians that when they bill HCPCS codes G0064 and G0065, they are stating that all of the criteria in §15513.B are met. Therefore, they must maintain documentation that demonstrates that all of the requirements for billing the code are met, including notations in medical records of the duration of telephone calls. Documentation supplied by home health agencies or hospices may not be used in lieu of a physician's documentation.

F. Provider Number of HHA or Hospice.--For claims for CPO submitted on or after January 1, 1997, physicians must enter on the Medicare claim form the 6-character Medicare provider number of the HHA or hospice providing Medicare covered services to the beneficiary for the period during which CPO services were furnished and for which the physician signed the plan of care. Physicians are responsible for obtaining the HHA or hospice Medicare provider numbers. Additionally, physicians should provide their UPIN to the HHA or hospice furnishing services to their patient.

15514. PREVENTIVE MEDICINE SERVICES (EXCLUDING IMMUNIZATIONS), NEWBORN SERVICES, AND OTHER EVALUATION AND MANAGEMENT SERVICES (CODES 99381-99499)

A. Preventive Medicine Services.--Do not pay for preventive medicine services (codes 99401-99440) because Medicare law specifically excludes coverage of preventive medicine services. See §15501.E when covered services are furnished during the same encounter as preventive medicine services.

B. Other Evaluation and Management Services.--Advise physicians to submit documentation when billing for unlisted evaluation and management services. If the services are covered, pay based upon the nature of the service. If you find that the service could or should have been billed using an existing code, base the payment upon the fee schedule payment for that code and advise the physician of how to correctly bill the service.

15515. HOME SERVICES (CODES 99341 - 99350)

A. Requirement for Physician Presence.--Pay home services codes 99341-99350 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.**

1999/2000 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	Work	Practice Expense	Mal-practice
00510	00	ALABAMA	0.978	0.872	0.876
00831	01	ALASKA	1.063	1.173	1.533
00832	00	ARIZONA	0.995	0.971	1.189
00520	13	ARKANSAS	0.953	0.855	0.403
02050	26	ANAHEIM/SANTA ANA, CA	1.036	1.191	0.846
02050	18	LOS ANGELES, CA	1.055	1.199	0.846
31140	03	MARIN/NAPA/SOLANO, CA	1.014	1.161	0.667
31140	07	OAKLAND/BERKLEY, CA	1.040	1.196	0.667
31140	05	SAN FRANCISCO, CA	1.067	1.299	0.667
31140	06	SAN MATEO, CA	1.047	1.274	0.667
31140	09	SANTA CLARA, CA	1.062	1.262	0.667
02050	17	VENTURA, CA	1.027	1.131	0.717
02050	99	REST OF STATE*	1.008	1.043	0.698
31140	99	REST OF STATE*	1.008	1.043	0.698
00824	01	COLORADO	0.987	0.970	0.795
10230	00	CONNECTICUT	1.049	1.172	1.052
00570	01	DELAWARE	1.019	1.028	0.860
00580	01	DC + MD/VA SUBURBS	1.050	1.161	1.032
00590	03	FORT LAUDERDALE, FL	0.996	1.026	1.783
00590	04	MIAMI, FL	1.015	1.077	2.350
00590	99	REST OF STATE	0.975	0.948	1.327
00511	01	ATLANTA, GA	1.006	1.034	0.951
00511	99	REST OF STATE	0.970	0.900	0.951
00833	01	HAWAII/GUAM	0.998	1.183	0.954
05130	00	IDAHO	0.960	0.892	0.566
00621	16	CHICAGO, IL	1.027	1.088	1.693
00621	12	EAST ST. LOUIS, IL	0.988	0.931	1.487
00621	15	SUBURBAN CHICAGO, IL	1.006	1.067	1.365
00621	99	REST OF STATE	0.963	0.886	0.990
00630	00	INDIANA	0.981	0.917	0.408
00826	00	IOWA	0.958	0.882	0.648
00650	00	KANSAS*	0.963	0.898	0.890
00740	04	KANSAS*	0.963	0.898	0.890
00660	00	KENTUCKY	0.970	0.874	0.807
00528	01	NEW ORLEANS, LA	0.998	0.950	1.153
00528	99	REST OF STATE	0.969	0.881	1.031
31142	03	SOUTHERN MAINE	0.979	1.030	0.708
31142	99	REST OF STATE	0.961	0.924	0.708
00901	01	BALTIMORE/SURR. CNTYS, MD	1.019	1.039	1.098
00901	99	REST OF STATE	0.985	0.986	0.866
31143	01	METROPOLITAN BOSTON	1.039	1.196	0.713
31143	99	REST OF STATE	1.010	1.093	0.713
00623	01	DETROIT, MI	1.042	1.022	3.069
00623	99	REST OF STATE	0.996	0.939	1.828
10240	00	MINNESOTA	0.989	0.967	0.507
10250	00	MISSISSIPPI	0.957	0.846	0.721
00740	02	METROPOLITAN KANSAS CITY, MO	0.988	0.949	1.196

B. Services of Nurse Practitioners (NP) in Nursing Facilities (Applies to Services in Non-Rural Areas After December 31, 1990).--

1. Limitations on Payments.--When a NP renders covered Medicare services at a nursing facility, the employer bills the program under the usual reasonable charge rules. Limit the prevailing charge for the service to 85 percent of the participating physician fee schedule amount for the comparable service when performed in a similar site of service.

2. Special Requirements for Reasonable Charge Payment.--

a. Employment Relationship.--Payment for the services of a NP may be made only to the actual employer of the NP. There must be a valid employment arrangement and the test used is the common law test of an employer-employee relationship. A group of NPs who have incorporated may not bill for their services.

b. Definition of a Team.--A team consists of a physician and a physician assistant acting under the supervision of the physician, or a nurse practitioner working in collaboration with the physician, or both. Team cannot be used to describe a medical group that does not employ either PAs or NPs. A team of one does not meet the definition of a team.

c. Assignment Requirement.--All claims for NP services must be made on an assignment basis.

d. Reasonable Charge Update.--Although NPs are not physicians, their services are not subject to the application of the inflation-indexed charge. (See §5025.) New customary and prevailing charges are computed on an annual basis. However, there is no index update. Instead, you must make an annual comparison to insure that the prevailing charge for NP services does not exceed the designated percentage of the updated physician fee schedule amount.

C. Services of Nurse Practitioners (NP) and Clinical Nurse Specialists (CNS) in Rural Areas After December 31, 1990.--

1. Payment Amounts.--Pay 80 percent of the lesser of the actual charge or the prevailing charge that would be recognized if a physician performed the service or, for services furnished on or after January 1, 1992, the fee schedule amount. Limit the recognized prevailing charge or fee schedule amount to:

- 75 percent of the participating physician fee schedule amount for services performed in a hospital; or

- 85 percent of the participating physician fee schedule amount for all other services.

2. Entity or Individual to Whom NP & CNS Payment is Made.--Make payment directly to the NP or CNS who furnishes the service or to a hospital, rural primary care hospital, SNF, nursing facility, physician, group practice, or ASC with which the nurse practitioner has an employment or contractual relationship. See §3060.1 for the information necessary to permit payment to an entity or person with which the NP or CNS has a contract.

3. Payment Limitations.--Pay for the services of a qualified NP or CNS only on an assignment related basis. The assignment agreed to by the NP is binding upon any person or entity who claims 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 NP or CNS for which payment may be made on an assignment related basis is subject to a civil monetary penalty not to exceed \$2000 for each such bill or request for payment.

16003. CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNAs)

A. General.--Anesthesia services furnished on or after January 1, 1992 by a qualified nurse anesthetist are subject to the usual Part B coinsurance and deductible and are paid at the lesser of the actual charge, the physician fee schedule, or the CRNA fee schedule.

B. Qualified Anesthetists.--For payment purposes, qualified anesthetists are CRNAs and anesthesiologist assistants (AA). An AA is a person who:

- Is permitted by State law to administer anesthesia; and
- Has successfully completed a 6 year program for AAs of which 2 years consist of specialized academic and clinical training in anesthesia.

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.

C. Entity or Individual to Whom Payment is Made Under the CRNA Fee Schedule.--Payment for the services of a qualified anesthetist may be made to the qualified anesthetist who furnishes anesthesia services or to a hospital, physician, group practice, or ambulatory surgical center with which the qualified anesthetist has an employment or contractual relationship. See §3060.1 for the information and procedures necessary to permit payment to an employer. Follow the procedures in §3060.2 for the information necessary to permit payment to an entity or person with which the qualified anesthetist has a contract.

D. CRNA Fee Schedule Payment.--Pay for the services of a qualified anesthetist only on an assignment related basis. The assignment agreed to by the qualified anesthetist is binding upon any other person or entity who claims 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 qualified