Medicare
Carriers Manual
Part 3 - Claims Process

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

Transmittal 1769 **Date: SEPTEMBER 12, 2002**

CHANGE REQUEST 2167

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter XV	15-1 - 15-2 (2 pp.)	15-1 - 15-2 (2 pp.)
15006 (Cont.)	15-4.1 (1 p.)	15-4.1 (1 p.)
15021.1 - 15022 (Cont.)	15-32.1 - 15-32.9 (9 pp.)	15 - 32.1 - 15-32.3 (3 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: October 1, 2002*
IMPLEMENTATION DATE: October 1, 2002

Section 15004, Method for Computing Fee Schedule Amounts, reflects the conversion factor for year 2002.

CLARIFICATION: EFFECTIVE DATE: Not Applicable

Section 15021.1, ICD-9-CM Coding for Diagnostic Tests, provides clarification on current ICD-9-CM Coding guidelines for reporting diagnostic tests. This transmittal manualizes CR 1724, Transmittal Number AB-01-144, dated September 26, 2001.

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

These instructions should be implemented within your current operating budget.

CHAPTER XV
FEE SCHEDULE FOR PHYSICIANS' SERVICES

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Appendix A - 2001 Geographic Practice Cost Indices by Medicare Carrier and
Locality

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

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

2002 $36.1992 2001 $38.2581 2000 $36.6137 1999 $34.7315 1998 $36.6873

1997	$40.9603(S) $33.8454(NS) $35.7671(PC)	1996	$40.7986(S) $34.6293(NS) $35.4173(PC)	1995	$39.447(S) $34.616(NS) $36.382(PC)	1994	$35.158(S) $32.905(NS) $33.718(PC)
1993	$31.962(S) $31.249(NS)	1992	$31.001				

S= Surgical NS= Nonsurgical PC= Primary Care

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

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

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

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

2002 - 100 percent of the resource-based RVUs.

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

<u>EXAMPLE of Computation of Fee Schedule Amount</u>

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

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

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

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

3. Patient Condition.--The radiologist may cancel, without notifying the treating physician/practitioner, an order because the beneficiary's physical condition at the time of diagnostic testing will not permit performance of the test (e.g., a barium enema cannot be performed because of residual stool in colon on scout KUB; PA/LAT of the chest cannot be performed because the patient is unable to stand). When an ordered diagnostic test is cancelled, any medically necessary preliminary or scout testing performed is payable.

F. Surgical/Cytopathology Exception.--This exception applies to an independent laboratory's pathologist or a hospital pathologist who furnishes a pathology service to a beneficiary who is not a hospital inpatient or outpatient, and where the treating physician/practitioner does not specifically request additional tests the pathologist may need to perform. When a surgical or cytopathology specimen is sent to the pathology laboratory, it typically comes in a labeled container with a requisition form that reveals the patient demographics, the name of the physician/practitioner, and a clinical impression and/or brief history. There is no specific order from the surgeon or the treating physician/practitioner for a certain type of pathology service. While the pathologist will generally perform some type of examination or interpretation on the cells or tissue, there may be additional tests, such as special stains, that the pathologist may need to perform, even though they have not been specifically requested by the treating physician/practitioner. The pathologist may perform such additional tests under the following circumstances:

1. These services are medically necessary so that a complete and accurate diagnosis can be reported to the treating physician/practitioner;

2. The results of the tests are communicated to and are used by the treating physician/practitioner in the treatment of the beneficiary; and

3. The pathologist documents in his/her report why additional testing was done.

EXAMPLE: A lung biopsy is sent by the surgeon to the pathology department, and the pathologist finds a granuloma which is suspicious for tuberculosis. The pathologist cultures the granuloma, sends it to bacteriology, and requests smears for acid fast bacilli (tuberculosis). The pathologist is expected to determine the need for these studies so that the surgical pathology examination and interpretation can be completed and the definitive diagnosis reported to the treating physician for use in treating the beneficiary.

15021.1 ICD-9-CM Coding for Diagnostic Tests.--

As required by the Health Insurance Portability and Accountability Act (HIPAA), the Secretary published a rule designating the ICD-9-CM and its *Official ICD-9-CM Guidelines for Coding and Reporting* as one of the approved code sets for use in reporting diagnoses and inpatient procedures. This final rule requires the use of ICD-9-CM and its official coding and reporting guidelines by most health plans (including Medicare) by October 16, 2002. The Administrative Simplification Act of 2001, however, permits plans and providers to apply for an extension until October 16, 2003. HHS anticipates that most plans and providers will obtain this extension.

The *Official ICD-9-CM Guidelines for Coding and Reporting* provides guidance on coding. The ICD-9-CM Coding Guidelines for Outpatient Services, which is part of the *Official ICD-9-CM Guidelines for Coding and Reporting,* provides guidance on diagnosis coding specific to outpatient facilities and physician offices.

The ICD-9-CM Coding Guidelines for Outpatient Services (hospital-based and physician office) have instructed physicians to report diagnoses based on test results. The Coding Clinic for ICD-9-CM confirms this longstanding coding guideline. CMS conforms with these longstanding official coding and reporting guidelines.

The following are instructions and examples for coding specialists, contractors, physicians, hospitals, and other health care providers to use in determining the use of ICD-9-CM codes for coding diagnostic test results. The instructions below provide guidance on the appropriate assignment of ICD-9-CM diagnosis codes to simplify coding for diagnostic tests consistent with the ICD-9-CM Guidelines for Outpatient Services (hospital-based and physician office). Note that physicians are responsible for the accuracy of the information submitted on a bill.

Additional examples of using ICD-9-CM codes consistently with ICD-9-CM Coding Guidelines for Outpatient Services are provided at the end of this section.

A. Determining the Appropriate Primary ICD-9-CM Diagnosis Code For Diagnostic Tests Ordered Due to Signs and/or Symptoms.--

1. If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis.

EXAMPLE 1: A surgical specimen is sent to a pathologist with a diagnosis of "mole." The pathologist personally reviews the slides made from the specimen and makes a diagnosis of "malignant melanoma". The pathologist should report a diagnosis of "malignant melanoma" as the primary diagnosis.

EXAMPLE 2: A patient is referred to a radiologist for an abdominal CT scan with a diagnosis of abdominal pain. The CT scan reveals the presence of an abscess. The radiologist should report a diagnosis of "intra-abdominal abscess."

EXAMPLE 3: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "cough". The chest x-ray reveals a 3 cm peripheral pulmonary nodule. The radiologist should report a diagnosis of "pulmonary nodule" and may sequence "cough" as an additional diagnosis.

2. If the diagnostic test did not provide a definitive diagnosis or was normal, the testing facility or the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

EXAMPLE 1: A patient is referred to a radiologist for a spine x-ray due to complaints of "back pain". The radiologist performs the x-ray, and the results are normal. The radiologist should report a diagnosis of "back pain" since this was the reason for performing the spine x-ray.

EXAMPLE 2: A patient is seen in the ER for chest pain. An EKG is normal, and the final diagnosis is chest pain due to suspected gastroesophageal reflux disease (GERD). The patient was told to follow-up with his primary care physician for further evaluation of the suspected GERD. The primary diagnosis code for the EKG should be chest pain. Although the EKG was normal, a definitive cause for the chest pain was not determined.

3. If the results of the diagnostic test are normal or non-diagnostic, and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probable, suspected, questionable, rule out, or working), then the interpreting physician should not code the referring diagnosis. Rather, the interpreting physician should report the sign(s) or symptom(s) that prompted the study. Diagnoses labeled as uncertain are considered by the ICD-9-CM Coding Guidelines as unconfirmed and should not be reported. This is consistent with the requirement to code the diagnosis to the highest degree of certainty.

EXAMPLE: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "rule out pneumonia." The radiologist performs a chest x-ray, and the results are normal. The radiologist should report the sign(s) or symptom(s) that prompted the test (e.g., cough).

B. Instruction to Determine the Reason for the Test.--As specified in §4317(b) of the Balanced Budget Act (BBA), referring physicians are required to provide diagnostic information to the testing entity at the time the test is ordered. As indicated in MCM §15021, the treating physician/practitioner must order all diagnostic tests furnished to a beneficiary who is not an institutional inpatient or outpatient. As further defined in §15021 of this manual, an "order" is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. Section 15021 provides a definition of an "order." Note if the order is communicated via telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

1. On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient's medical record if it is available. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

EXAMPLE: A patient is referred to a radiologist for a gastrograffin enema to rule out appendicitis. However, the referring physician does not provide the reason for the referral and is unavailable at the time of the study. The patient is queried and indicates that he/she saw the physician for abdominal pain, and was referred to rule out appendicitis. The radiologist performs the x- ray, and the results are normal. The radiologist should report the abdominal pain as the primary diagnosis.

2. In the event the physician's interpretation of the test result is not clear or ambiguously stated in the patient's medical record, contact either the attending physician or the physician that performed the test for clarification. This may result in the reporting of symptoms or a confirmed diagnosis.

3. If the test (i.e., lab test) has been performed and the results are back, but the patient's physician has not yet reviewed them to make a diagnosis, or there is no physician interpretation, then code the symptom or the diagnosis provided by the referring physician.

4. In the event the individual responsible for reporting the codes for the testing facility or the

physician's office does not have the report of the physician interpretation at the time of billing, the individual responsible for reporting the codes for the testing facility or the physician's office should code what they know at the time of billing. Sometimes reports of the physician's interpretation of diagnostic tests may not be available until several days later, which could result in delay of billing. Therefore, in such instances, the individual responsible for reporting the codes for the testing facility or the physician's office should code based on the information/reports available to them, or what they know, at the time of billing.

C. Incidental Findings.--Incidental findings should never be listed as primary diagnoses. If reported, incidental findings may be reported as secondary diagnoses by the physician interpreting the diagnostic test

EXAMPLE 1: A patient is referred to a radiologist for an abdominal ultrasound due to jaundice. After review of the ultrasound, the interpreting physician discovers that the patient has an aortic aneurysm. The interpreting physician reports jaundice as the primary diagnosis and may report the aortic aneurysm as a secondary diagnosis because it is an incidental finding.

EXAMPLE 2: A patient is referred to a radiologist for a chest x-ray because of wheezing. The x-ray is normal except for scoliosis and degenerative joint disease of the thoracic spine. The interpreting physician reports wheezing as the primary diagnosis since it was the reason for the patient's visit and may report the other findings (scoliosis and degenerative joint disease of the thoracic spine) as additional diagnoses.

EXAMPLE 3: A patient is referred to a radiologist for a magnetic resonance imaging (MRI) of the lumbar spine with a diagnosis of L-4 radiculopathy. The MRI reveals degenerative joint disease at L1 and L2. The radiologist reports radiculopathy as the primary diagnosis and may report degenerative joint disease of the spine as an additional diagnosis.

D. Unrelated/Co-Existing Conditions/Diagnoses.--Unrelated and co-existing conditions/diagnosis may be reported as additional diagnoses by the physician interpreting the diagnostic test.

EXAMPLE: A patient is referred to a radiologist for a chest x-ray because of a cough. The result of the chest x-ray indicates the patient has pneumonia. During the performance of the diagnostic test, it was determined that the patient has hypertension and diabetes mellitus. The interpreting physician reports a primary diagnosis of pneumonia. The interpreting physician may report the hypertension and diabetes mellitus as secondary diagnoses.

E. Diagnostic Tests Ordered in the Absence of Signs and/or Symptoms (e. g., screening tests).- When a diagnostic test is ordered in the absence of signs/symptoms or other evidence of illness or injury, the testing facility or the physician interpreting the diagnostic test should report the screening code as the primary diagnosis code. Any condition discovered during the screening should be reported as a secondary diagnosis.

NOTE: This instruction does NOT preclude current statutory payment guidelines (i.e., Medicare's screening colonoscopy or sigmoidoscopy reporting guidelines. If during

the course of a screening colonoscopy or sigmoidoscopy, a lesion or growth is detected, the lesion or growth should be reported as the primary diagnosis. This is consistent with the instruction in Section A.).

F. Use of ICD-9-CM To The Greatest Degree of Accuracy and Completeness.**--**

NOTE: This section explains certain coding guidelines that address diagnosis coding. These guidelines are longstanding coding guidelines that have been part of the *Official ICD-9-CM Guidelines for Coding and Reporting.*

The testing facility or the interpreting physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness for the diagnosis resulting from the test, or for the sign(s)/symptom(s) that prompted the ordering of the test.

In the past, there has been some confusion about the meaning of "highest degree of specificity," and "reporting the correct number of digits." In the context of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description in the medical chart of the symptom or diagnosis.

EXAMPLE 1: A chest x-ray reveals a primary lung cancer in the left lower lobe. The interpreting physician should report the ICD-9-CM code as 162.5 for malignancy of the "left lower lobe, bronchus or lung", not the code for a malignancy of "other parts of bronchus or lung" (162.8) or the code for "bronchus and lung unspecified" (162.9).

EXAMPLE 2: If a sputum specimen is sent to a pathologist and the pathologist confirms growth of "streptococcus, type B" which is indicated in the patient's medical record, the pathologist should report a primary diagnosis as 482.32 (Pneumonia due to streptococcus, Group B). However, if the pathologist is unable to specify the organism, then the pathologist should report the primary diagnosis as 486 (Pneumonia, organism unspecified).

In order to report the correct number of digits when using ICD-9-CM, refer to the following instructions:

ICD-9-CM diagnosis codes are composed of codes with 3, 4, or 5 digits. Codes with 3 digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits to provide greater specificity. Assign three-digit codes only if there are no four-digit codes within that code category. Assign four-digit codes only if there is no fifth-digit subclassification for that category. Assign the fifth-digit subclassification code for those categories where it exists.

EXAMPLE 3: A patient is referred to a physician with a diagnosis of diabetes mellitus. However, there is no indication that the patient has diabetic complications or that the diabetes is out of control. It would be incorrect to assign code 250

since all codes in this series have 5 digits. Reporting only three digits of a code that has 5 digits would be incorrect. One must add two more digits to make it complete. Because the type (adult onset/juvenile) of diabetes is not specified, and there is no indication that the patient has a complication or that the diabetes is out of control, the correct ICD-9-CM code would be 250.00. The fourth and fifth digits of the code would vary depending on the specific condition of the patient. One should be guided by the code book.

For the latest ICD-9-CM coding guidelines, please refer to the following Web site: http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guide.

Refer to the following questions and answers for further guidance on determining the appropriate ICD-9-CM diagnoses codes. The questions and answers appeared in the American Hospital Association's (AHA) Coding Clinic for ICD-9-CM (1st Qtr 2000).

EXAMPLES:

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Question 1: A skin lesion of the cheek is surgically removed and submitted to the pathologist for analysis. The surgeon writes on the pathology order, "skin lesion." The pathology report comes back with the diagnosis of "basal cell carcinoma." A laboratory-billing consultant is recommending that the ordering physician's diagnosis be reported instead of the final diagnosis obtained by the pathologist. Also, an insurance carrier is also suggesting this case be coded to "skin lesion" since the surgeon did not know the nature of the lesion at the time the tissue was sent to pathology. Which code should the pathologist use to report his claim?

Answer 1: The pathologist is a physician and if a diagnosis is made it can be coded. It is appropriate for the pathologist to code what is known at the time of code assignment. For example, if the pathologist has made a diagnosis of basal cell carcinoma, assign code 173.3, Other malignant neoplasm of skin, skin of other and unspecified parts of face. If the pathologist had not come up with a definitive diagnosis, it would be appropriate to code the reason why the specimen was submitted, in this instance, the skin lesion of the cheek.

Question 2: A patient presents to the hospital for outpatient x-rays with a diagnosis on the physician's orders of questionable stone. The abdominal x-ray diagnosis per the Radiologist is "bilateral nephrolithiasis with staghorn calculi." No other documentation is available. Is it correct to code this as 592.0, Calculus of kidney, based on the radiologist's diagnosis?

Answer 2: The radiologist is a physician and he/she diagnosed the nephrolithiasis. Therefore, it is appropriate to code this case as 592.0, Calculus of kidney.

Question 3: A patient undergoes outpatient surgery for removal of a breast mass. The pre- and post-operative diagnosis is reported as "breast mass." The pathological diagnosis is fibroadenoma. How should the hospital outpatient coder code this? Previous *Coding Clinic* advice has precluded us from assigning codes on the basis of laboratory findings. Does the same advice apply to pathological reports?

Answer 3: Previously published advice has warned against coding from laboratory results alone, without physician interpretation. However, the pathologist is a physician and the pathology report serves as the pathologist's interpretation and a microscopic confirmatory report regarding the morphology of the tissue excised. Therefore, a

pathology report provides greater specificity. Assign code 217, Benign neoplasm of breast, for the fibroadenoma of the breast. It is appropriate for coders to code based on the physician documentation available at the time of code assignment.

Question 4: A referring physician sent a urine specimen to the cytology lab for analysis with a diagnosis of "hematuria" (code 599.7). However, a cytology report authenticated by the pathologist revealed abnormal cells consistent with transitional cell carcinoma of the bladder. Although the referring physician assigned code 599.7, Hematuria, the laboratory reported code 188.9, Malignant neoplasm of bladder, Bladder, part unspecified. For reporting purposes, what would be the appropriate diagnosis code for the laboratory and the referring physician?

Answer 4: The laboratory should report code 188.9, Malignant neoplasm of bladder, Bladder, part unspecified. It is appropriate to code the carcinoma, in this instance, because the cytology report was authenticated by the pathologist and serves as confirmation of the cell type, similar to a pathology report. The referring physician should report code 599.7Hematuria, if the result of the cytological analysis is not known at the time of code assignment.

Question 5: A patient presents to the physician's office with complaints of urinary frequency and burning. The physician ordered a urinalysis and the findings were positive for bacteria and increased WBCs in the urine. Based on these findings a urine culture was ordered and was positive for urinary tract infection. Should the lab report the "definitive diagnosis," urinary tract infection, or is it more appropriate for the lab to report the signs and symptoms when submitting the claim?

Answer 5**:** Since this test does not have physician interpretation, the laboratory (independent or hospital-based) should code the symptoms (i.e., urinary frequency and burning).

Question 6**:** The physician refers a patient for chest x-ray to outpatient radiology with a diagnosis of weakness and chronic myelogenous leukemia (CML). The radiology report demonstrated no acute disease and moderate hiatal hernia. For reporting purposes, which codes are appropriate for the facility to assign?

Answer 6**:** Assign code 780.79, Other malaise and fatigue, and code 205.10, Myeloid leukemia, without mention of remission, for this encounter. It is not necessary to report code 553.3, Diaphragmatic hernia, for the hiatal hernia, because it is an incidental finding.

(For CMS purposes, the primary diagnosis would be reported as 780.79 (Other malaise and fatigue), and the secondary diagnosis as 205.10 (Myeloid leukemia, without mention of remission, for this encounter)).

Question 7**:** A patient presents to the doctor's office with a complaint of fatigue. The physician orders a complete blood count (CBC). The CBC reveals a low hemoglobin and hematocrit. Should the lab report the presenting symptom fatigue (code 780.79) or the finding of anemia (code 285.9)?

Answer 7: The laboratory (independent or hospital-based) should code the symptoms, because no physician has interpreted the results. Assign code 780.79, Other malaise and fatigue, unless the lab calls the physician to confirm the diagnosis of anemia.

15022. PAYMENT CONDITIONS FOR RADIOLOGY SERVICES

A. Professional Component (PC).--Pay for the PC of radiology services furnished by a physician to an individual patient in all settings under the fee schedule for physician services regardless of the specialty of the physician who performs the service. For services furnished to

hospital patients, pay only if the services meet the conditions for fee schedule payment in §15014.C.1 and are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as an interpretation of diagnostic procedures and the PC of therapeutic procedures. The interpretation of a diagnostic procedure includes a written report.

B. Technical Component TC).--

1. Hospital Patients.--Do not pay for the TC of radiology services furnished to Hospital patients. Payments for physicians' radiological services to the hospital, e.g., Administrative or supervisory services, and for provider services needed to produce the radiology service is made by the intermediary as provider services through various payment mechanisms.

2. Services Not Furnished in Hospitals.--Pay under the fee schedule for the TC of radiology services furnished to beneficiaries who are not patients of any hospital in a physician's office, a freestanding imaging or radiation oncology center, or other setting that is not part of a hospital.

3. Services Furnished in Leased Departments.--In the case of procedures furnished in a leased hospital radiology department to a beneficiary who is neither an inpatient nor an outpatient of any hospital, e.g., the patient is referred by an outside physician and is not registered as a hospital outpatient, both the PC and the TC of the services are payable under the fee schedule.

4. Purchased TC Services.--Apply the purchased services limitation as set forth in §15048 to the TC of radiologic services other than screening mammography procedures.

5. Computerized Axial Tomography (CT) Procedures.--Do not reduce or deny payment for medically necessary multiple CT scans of different areas of the body that are performed on the same day.

The TC RVUs for CT procedures that specify "with contrast" include payment for high osmolar contrast media. When separate payment is made for low osmolar contrast media under the conditions set forth in subsection F.1, reduce payment for the contrast media as set forth in subsection F.2.

6. Magnetic Resonance Imaging (MRI) Procedures.--Do not make additional payments for 3 or more MRI sequences. The RVUs reflect payment levels for 2 sequences.

The TC RVUs for MRI procedures that specify "with contrast" include payment for paramagnetic contrast media. Do not make separate payment under code A4647.

A diagnostic technique has been developed under which an MRI of the brain or spine is first performed without contrast material, then another MRI is performed with a standard (0.1mmol/kg) dose of contrast material and, based on the need to achieve a better image, a third MRI is performed with an additional double dosage (0.2mmol/kg) of contrast material. When the high-dose contrast technique is utilized:

- o Do not pay separately for the contrast material used in the second MRI procedure;

- o Pay for the contrast material given for the third MRI procedure through supply code A4643 when billed with CPT codes 70553, 72156, 72157, and 72158;

o Do not pay for the third MRI procedure. For EXAMPLE, in the case of an MRI of the brain, if CPT code 70553 (without contrast material, followed by with contrast material(s) and further sequences) is billed, make no payment for CPT code 70551 (without contrast material(s)), the additional procedure given for the purpose of administering the double dosage, furnished during the same session. Medicare does not pay for the third procedure (as distinguished from the contrast material) because the CPT definition of code 70553 includes all further sequences; and

o Do not apply the payment criteria for low osmolar contrast media in subsection F to billings for code A4643.

7. Stressing Agent.--Make separate payment under code J1245 for pharmacologic stressing agents used in connection with nuclear medicine and cardiovascular stress testing procedures furnished to beneficiaries in settings in which TCs are payable. Such an agent is classified as a supply and covered as an integral part of the diagnostic test. However, pay for code J1245 under the policy for determining payments for "incident to" drugs.

C. Nuclear Medicine (CPT 78000 Through 79999).--

1. Payments for Radionuclides.--The TC RVUs for nuclear medicine procedures (CPT codes 78XXX for diagnostic nuclear medicine, and codes 79XXX for therapeutic nuclear medicine) do not include the radionuclide used in connection with the procedure. These substances are separately billed under codes A4641 and A4642 for diagnostic procedures and code 79900 for therapeutic procedures and are paid on a “By Report” basis depending on the substance used. In addition, CPT code 79000 is separately payable in connection with certain clinical brachytherapy procedures. (See subsection D.3.)

2. Application of Multiple Procedure Policy (CPT Modifier 51).--Apply the multiple procedure reduction as set forth in §15038 to the following nuclear medicine diagnostic procedures: codes 78306, 78320, 78803, 78806, and 78807.

3. Generation and Interpretation of Automated Data.--Payment for CPT codes 78890 and 78891 is bundled into payments for the primary procedure.