

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2997	Date: July 25, 2014
	Change Request 8688

SUBJECT: Update to Pub. 100-04, Chapter 12 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

I. SUMMARY OF CHANGES: This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 12. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: January 1, 2012

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: August 25, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/30.6.12/ Critical Care Visits and Neonatal Intensive Care (Codes 99291 99292)
R	12/40.2/ Billing Requirements for Global Surgeries
R	12/40.3/ Claims Review for Global Surgeries
R	12/40.4/ Adjudication of Claims for Global Surgeries
R	12/200/ Allergy Testing and Immunotherapy

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2997	Date: July 25, 2014	Change Request: 8688
-------------	-------------------	---------------------	----------------------

SUBJECT: Update to Pub. 100-04, Chapter 12 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

EFFECTIVE DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: January 1, 2012

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: August 25, 2014

I. GENERAL INFORMATION

A. Background: This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 12.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C S	Shared-System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
8688.1	A/B MACs shall be aware of the updated language for ICD-10 and for ASC X12 in Chapter 12 of Pub. 100 - 04.		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C S	C E D I
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

(Rev. 2997, 07-25-2014)

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

(Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01-2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10)

CRITICAL CARE SERVICES (CODES 99291-99292)

A. Use of Critical Care Codes

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

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

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

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

Critical care is usually, but not always, given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care.

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

B. Critical Care Services and Medical Necessity

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

As described in Section A, critical care services encompass both treatment of "vital organ failure" and "prevention of further life threatening deterioration of the patient's condition." Therefore, although critical care may be delivered in a moment of crisis or upon being called to the patient's bedside emergently, this is not a requirement for providing critical care service. The treatment and management of the patient's

condition, while not necessarily emergent, shall be required, based on the threat of imminent deterioration (i.e., the patient shall be critically ill or injured at the time of the physician's visit).

Chronic Illness and Critical Care:

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

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

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

1. An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and pressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
2. A 67 year old female patient is 3 days status post mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.
3. A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive 2 days after admission.
4. A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

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

1. Patients admitted to a critical care unit because no other hospital beds were available;
2. Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose); and
3. Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

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

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

C. Critical Care Services and Full Attention of the Physician

The duration of critical care services to be reported is the time the physician spent evaluating, providing care and managing the critically ill or injured patient's care. That time must be spent at the immediate bedside or elsewhere on the floor or unit so long as the physician is immediately available to the patient.

For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor may be reported as critical care, even when it does not occur at the bedside, if this time represents the physician's full attention to the management of the critically ill/injured patient.

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

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

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

E. Critical Care Services and Physician Time

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

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

1. Off the Unit/Floor

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

2. Split/Shared Service

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

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

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

3. Unbundled Procedures

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

4. Family Counseling/Discussions

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

- a) The patient is unable or incompetent to participate in giving a history and/or making treatment decisions, and
- b) The discussion is necessary for determining treatment decisions.

For family discussions, the physician should document:

- a. The patient is unable or incompetent to participate in giving history and/or making treatment decisions
- b. The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family",
- c. Medically necessary treatment decisions for which the discussion was needed, and
- d. A summary in the medical record that supports the medical necessity of the discussion

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

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

Time involved in activities that do not directly contribute to the treatment of the critically ill or injured patient may not be counted towards the critical care time, even when they are performed in the critical care unit at a patient's bedside (e.g., review of literature, and teaching sessions with physician residents whether conducted on hospital rounds or in other venues).

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

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

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

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

Clinical Example of Correct Billing of Time:

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

G. Counting of Units of Critical Care Services

The CPT code 99291 (critical care, first hour) is used to report the services of a physician providing full attention to a critically ill or critically injured patient from 30-74 minutes on a given date. Only one unit of CPT code 99291 may be billed by a physician for a patient on a given date. Physicians of the same specialty

within the same group practice bill and are paid as though they were a single physician and would not each report CPT 99291 on the same date of service.

The following illustrates the correct reporting of critical care services:

Total Duration of Critical Care

Codes

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

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

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

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

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

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

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

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

CPT Code 99291

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

CPT Code 99292

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

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

Physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the contractor that adjudicates the claims. Physicians in the same group practice who have different medical specialties may bill and be paid without regard to their membership in the same group. For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically necessary and not duplicative, the critical care services may be reported by each regardless of their group practice relationship.

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

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

Clinical Examples of Critical Care Services

1. Drs. Smith and Jones, pulmonary specialists, share a group practice. On Tuesday Dr. Smith provides critical care services to Mrs. Benson who is comatose and has been in the intensive care unit for 4 days following a motor vehicle accident. She has multiple organ dysfunction including cerebral hematoma, flail chest and pulmonary contusion. Later on the same calendar date Dr. Jones covers for Dr. Smith and provides critical care services. Medically necessary critical care services provided at the different time periods may be reported by both Drs. Smith and Jones. Dr. Smith would report CPT code 99291 for the initial visit and Dr. Jones, as part of the same group practice would report CPT code 99292 on the same calendar date if the appropriate time requirements are met.
2. Mr. Marks, a 79 year old comes to the emergency room with vague joint pains and lethargy. The ED physician evaluates Mr. Marks and phones his primary care physician to discuss his medical

evaluation. His primary care physician visits the ER and admits Mr. Marks to the observation unit for monitoring, and diagnostic and laboratory tests. In observation Mr. Marks has a cardiac arrest. His primary care physician provides 50 minutes of critical care services. Mr. Marks' is admitted to the intensive care unit. On the same calendar day Mr. Marks' condition deteriorates and he requires intermittent critical care services. In this scenario the ED physician should report an emergency department visit and the primary care physician should report both an initial hospital visit and critical care services.

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

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

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

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

K. Global Surgery

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

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

the pre, intra, and post procedure work of these unbundled services, e.g., endotracheal intubation, shall be excluded from the determination of the time spent providing critical care.

This policy applies to any procedure with a 0, 10 or 90 day global period including cardiopulmonary resuscitation (CPT code 92950). CPR has a global period of 0 days and is not bundled into critical care codes. Therefore, critical care may be billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing CPR shall be excluded from the determination of the time spent providing critical care. In this instance it must be the physician who performs the resuscitation who bills for this service. Members of a code team must not each bill Medicare Part B for this service.

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

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

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

- *For preoperative care modifier -25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) must be used with the HCPCS code*
- *For postoperative care modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) must be used with the HCPCS code.*

In addition, for each preoperative and postoperative care the diagnosis must clearly indicate that the critical care was unrelated to the surgery.

M. Teaching Physician Criteria

In order for the teaching physician to bill for critical care services the teaching physician must meet the requirements for critical care described in the preceding sections. For CPT codes determined on the basis of time, such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes. (See IOM, Pub 100-04, Chapter 12, § 100.1.4)

1. Teaching

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

2. Documentation

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

Unacceptable Example of Documentation:

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

Acceptable Example of Documentation:

"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."

N. Ventilator Management

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

40.2 - Billing Requirements for Global Surgeries

(Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01-2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10)

To ensure the proper identification of services that are, or are not, included in the global package, the following procedures apply.

A. Procedure Codes and Modifiers

Use of the modifiers in this section apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers "-22" and "-25").

1. Physicians Who Furnish the Entire Global Surgical Package

Physicians who perform the surgery and furnish all of the usual pre-and postoperative work bill for the global package by entering the appropriate CPT code for the surgical procedure only. Billing is not allowed for visits or other services that are included in the global package.

2. Physicians in Group Practice

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician. (For dates of service prior to January 1, 1994, however,

where a new physician furnishes the entire postoperative care, the group billed for the surgical care and the postoperative care as separate line items with the appropriate modifiers.)

3. Physicians Who Furnish Part of a Global Surgical Package

Where physicians agree on the transfer of care during the global period, the following modifiers are used:

- “-54” for surgical care only; or
- “-55” for postoperative management only.

Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier.

Providers need not specify on the claim that care has been transferred. However, the date on which care was relinquished or assumed, as applicable, must be shown on the claim. This should be indicated in the remarks field/free text segment on the claim form/format. Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary’s medical record.

Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service. Once the physician has seen the patient, that physician may bill for the period beginning with the date on which he/she assumes care of the patient.

EXCEPTIONS:

- Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate evaluation and management code. No modifiers are necessary on the claim.
- If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care bills using subsequent hospital care codes for the inpatient hospital care and the surgical code with the “-55” modifier for the post-discharge care. The surgeon bills the surgery code with the “-54” modifier.
- Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier.
- If the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate evaluation and management code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular conditions of a patient.

4. Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery

Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.

In addition to the CPT evaluation and management code, modifier “-57” (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery. (Modifier “-QI” was used for dates of service prior to January 1, 1994.)

If evaluation and management services occur on the day of surgery, the physician bills using modifier “-57,” not “-25.” The “-57” modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.

5. Return Trips to the Operating Room During the Postoperative Period

When treatment for complications requires a return trip to the operating room, physicians must bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unspecified procedure code in the correct series, i.e., 47999 or 64999. The procedure code for the original surgery is not used except when the **identical** procedure is repeated.

In addition to the CPT code, physicians use CPT modifier “-78” for these return trips (return to the operating room for a related procedure during a postoperative period.)

The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first procedure and requires the use of the operating room, this circumstance may be reported by adding the modifier “-78” to the related procedure.

NOTE: The CPT definition for this modifier does not limit its use to treatment for complications.

6. Staged or Related Procedures

Modifier “-58” was established to facilitate billing of staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.

The physician may need to indicate that the performance of a procedure or service during the postoperative period was:

- a. Planned prospectively or at the time of the original procedure;
- b. More extensive than the original procedure; or
- c. For therapy following a diagnostic surgical procedure.

These circumstances may be reported by adding modifier “-58” to the staged procedure. A new postoperative period begins when the next procedure in the series is billed.

7. Unrelated Procedures or Visits During the Postoperative Period

Two CPT modifiers were established to simplify billing for visits and other procedures which are furnished during the postoperative period of a surgical procedure, but which are not included in the payment for the surgical procedure.

Modifier “-79”: Reports an unrelated procedure by the same physician during a postoperative period. The physician may need to indicate that the performance of a procedure or service during a postoperative period was unrelated to the original procedure.

A new postoperative period begins when the unrelated procedure is billed.

Modifier “-24”: Reports an unrelated evaluation and management service by same physician during a postoperative period. The physician may need to indicate that an evaluation and management service was performed during the postoperative period of an unrelated procedure. This circumstance is reported by adding the modifier “-24” to the appropriate level of evaluation and management service.

Services submitted with the “-24” modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. A *diagnosis* code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

A physician who is responsible for postoperative care and has reported and been paid using modifier “-55” also uses modifier “-24” to report any unrelated visits.

8. Significant Evaluation and Management on the Day of a Procedure

Modifier “-25” is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made.

It is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier “-25” to the appropriate level of evaluation and management service.

Claims containing evaluation and management codes with modifier “-25” are not subject to prepayment review except in the following situations:

- Effective January 1, 1995, all evaluation and management services provided on the same day as inpatient dialysis are denied without review with the exception of CPT Codes 99221-9223, 99251-99255, and 99238. These codes may be billed with modifier “-25” and reviewed for possible allowance if the evaluation and management service is unrelated to the treatment of ESRD and was not, and could not, have been provided during the dialysis treatment;
- When preoperative critical care codes are being billed for within a global surgical period; and
- When *A/B MACs (B)* have conducted a specific medical review process and determined, after reviewing the data, that an individual or group have high statistics in terms of the use of modifier “-25,” have done a case-by-case review of the records to verify that the use of modifier “-25” was inappropriate, and have educated the individual or group as to the proper use of this modifier.

9. Critical Care

Critical care services provided during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances.

Preoperative and postoperative critical care may be paid in addition to a global fee if:

- The patient is critically ill and requires the constant attendance of the physician; and
- The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed.

Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

Modifier -24 (post-operative) or -25 (same day pre-operative) is used to indicate that the critical care service is unrelated to the procedure.

10. Unusual Circumstances

Surgeries for which services performed are significantly greater than usually required may be billed with the “-22” modifier added to the CPT code for the procedure. Surgeries for which services performed are significantly less than usually required may be billed with the “-52” modifier. The biller must provide:

- A concise statement about how the service differs from the usual; and
- An operative report with the claim.

Modifier “-22” should only be reported with procedure codes that have a global period of 0, 10, or 90 days. There is no such restriction on the use of modifier “-52.”

B. Date(s) of Service

Physicians, who bill for the entire global surgical package or for only a portion of the care, must enter the date on which the surgical procedure was performed in the “From/To” date of service field. This will enable *A/B MACs (B)* to relate all appropriate billings to the correct surgery. Physicians who share postoperative management with another physician must submit additional information showing when they assumed and relinquished responsibility for the postoperative care. If the physician who performed the surgery relinquishes care at the time of discharge, he or she need only show the date of surgery when billing with modifier “-54.”

However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician. The physician providing the remaining postoperative care must show the date care was assumed. This information should be shown in Item 19 on the paper Form CMS-1500. *See the related implementation guide for where to show this information on the ASC X12 837 professional claim transaction format.*

C. Care Provided in Different Payment Localities

If portions of the global period are provided in different payment localities, the services should be billed to the *A/B MAC (B)* servicing each applicable payment locality. For example, if the surgery is performed in one state and the postoperative care is provided in another state, the surgery is billed with modifier “-54” to the *A/B MAC (B)* servicing the payment locality where the surgery was performed and the postoperative care is billed with modifier “-55” to the *A/B MAC (B)* servicing the payment locality where the postoperative care was performed. This is true whether the services were performed by the same physician/group or different physicians/groups.

D. Health Professional Shortage Area (HPSA) Payments for Services Which are Subject to the Global Surgery Rules

HPSA bonus payments may be made for global surgeries when the services are provided in HPSAs. The following are guidelines for the appropriate billing procedures:

- If the entire global package is provided in a HPSA, physicians should bill for the appropriate global surgical code with the applicable HPSA modifier.
- If only a portion of the global package is provided in a HPSA, the physician should bill using a HPSA modifier for the portion which is provided in the HPSA.

EXAMPLE

The surgical portion of the global service is provided in a non-HPSA and the postoperative portion is provided in a HPSA. The surgical portion should be billed with the “-54” modifier and no HPSA modifier. The postoperative portion should be billed with the “-55” modifier and the appropriate HPSA modifier. The 10 percent bonus will be paid on the appropriate postoperative portion only. If a claim is submitted with a global surgical code and a HPSA modifier, the *A/B MAC (B)* assumes that the entire global service was provided in a HPSA in the absence of evidence otherwise.

NOTE: The sum of the payments made for the surgical and postoperative services provided in different localities will not equal the global amount in either of the localities because of geographic adjustments made through the Geographic Practice Cost Indices.

40.3 - Claims Review for Global Surgeries

(Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01-2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10)

A. Relationship to Correct Coding Initiative (CCI)

The CCI policy and computer edits allow *A/B MACs (B)* to detect instances of fragmented billing for certain intra-operative services and other services furnished on the same day as the surgery that are considered to be components of the surgical procedure and, therefore, included in the global surgical fee. When both correct coding and global surgery edits apply to the same claim, *A/B MACs (B)* first apply the correct coding edits, then, apply the global surgery edits to the correctly coded services.

B. Prepayment Edits to Detect Separate Billing of Services Included in the Global Package

In addition to the correct coding edits, *A/B MACs (B)* must be capable of detecting certain other services included in the payment for a major or minor surgery or for an endoscopy. On a prepayment basis, *A/B MACs (B)* identify the services that meet the following conditions:

- Preoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure; or
 - Same day or postoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure or endoscopy;
- and -
- Services that were furnished within the prescribed global period of the surgical procedure;
 - Services that are billed without modifier “-78,” “-79,” “-24,” “25,” or “-57” or are billed with modifier “-24” but without the required documentation; and
 - Services that are billed with the same provider or group number as the surgical procedure or endoscopy. Also, edit for any visits billed separately during the postoperative period without modifier “-24” by a physician who billed for the postoperative care only with modifier “-55.”

A/B MACs (B) use the following evaluation and management codes in establishing edits for visits included in the global package. CPT codes 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254,

99255, 99271, 99272, 99273, 99274, and 99275 have been transferred from the excluded category and are now included in the global surgery edits.

Evaluation and Management Codes for *A/B MAC (B)* Edits

92012	92014	99211	99212	99213	99214
99215	99217	99218	99219	99220	99221
99222	99223	99231	99232	99233	99234
99235	99236	99238	99239	99241	99242
99243	99244	99245	99251	99252	99253
99254	99255	99261	99262	99263	99271
99272	99273	99274	99275	99291	99292
99301	99302	99303	99311	99312	99313
99315	99316	99331	99332	99333	99347
99348	99349	99350			
99374	99375	99377	99378		

NOTE: In order for codes 99291 or 99292 to be paid for services furnished during the preoperative or postoperative period, modifier “-25” or “-24,” respectively, must be used *to indicate* that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed.

If a surgeon is admitting a patient to a nursing facility for a condition not related to the global surgical procedure, the physician should bill for the nursing facility admission and care with a “-24” modifier and appropriate documentation. If a surgeon is admitting a patient to a nursing facility and the patient’s admission to that facility relates to the global surgical procedure, the nursing facility admission and any services related to the global surgical procedure are included in the global surgery fee.

C. Exclusions from Prepayment Edits

A/B MACs (B) exclude the following services from the prepayment audit process and allow separate payment if all usual requirements are met:

- Services listed in §40.1.B; and
- Services billed with the modifier “-25,” “-57,” “-58,” “-78,” or “-79.”

Exceptions

See §§40.2.A.8, 40.2.A.9, and 40.4.A for instances where prepayment review is required for modifier “-25.” In addition, prepayment review is necessary for CPT codes 90935, 90937, 90945, and 90947 when a visit and modifier “-25” are billed with these services.

Exclude the following codes from the prepayment edits required in §40.3.B.

92002	92004	99201	99202	99203	99204
99205	99281	99282	99283	99284	99285
99321	99322	99323	99341	99342	99343
99344	99345				

40.4 - Adjudication of Claims for Global Surgeries

(Rev. 2007, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01- 2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10)

A. Fragmented Billing of Services Included in the Global Package

Since the Medicare fee schedule amount for surgical procedures includes all services that are part of the global surgery package, *A/B MACs (B)* do not pay more than that amount when a bill is fragmented. When total charges for fragmented services exceed the global fee, process the claim as a fee schedule reduction

(except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global surgery allowed amount). *A/B MACs (B)* do not attribute such reductions to medical review savings except where the usual medical review process results in recoding of a service, and the recoded service is included in the global surgery package.

The maximum a nonparticipating physician may bill a beneficiary on an unassigned claim for services included in the global surgery package is the limiting charge for the surgical procedure.

In addition, the limitation of liability provision (§1879 of the Act) does not apply to these determinations since they are fee schedule reductions, not denials based upon medical necessity or custodial care.

Claims for surgeries billed with a “-22” or “-52” modifier, are priced by individual consideration if the statement and documentation required by §40.2.A.10 are included. If the statement and documentation are not submitted with the claim, pricing for “-22” is at the fee schedule rate for the same surgery submitted without the “-22” modifier. Pricing for “-52” is not done without the required documentation.

Separate payment is allowed for visits and procedures billed with modifier “-78,” “-79,” “-24,” “-25,” “-57,” or “-58.” Modifier “-24” must be accompanied by sufficient documentation that the visit is unrelated to the surgery. Also, when used with the critical care codes, modifiers “-24” and “-25” must be accompanied by documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed.

A/B MACs (B) do not allow separate payment for evaluation and management services furnished on the same day or during the postoperative period of a surgery if the services are billed without modifier “-24,” “-25,” or “-57.” These services should be denied. *A/B MACs (B)* do not allow separate payment for visits during the postoperative period that are billed with the modifier “-24” but without sufficient documentation. These services should also be denied. Modifier “-24” is intended for use with services that are absolutely unrelated to the surgery. It is not to be used for the medical management of a patient by the surgeon following surgery. Recognize modifier “-24” only for care following discharge unless:

- The care is for immunotherapy management furnished by the transplant surgeon;
- The care is for critical care for a burn or trauma patient; or
- The documentation demonstrates that the visit occurred during a subsequent hospitalization and the diagnosis supports the fact that it is unrelated to the original surgery.

A/B MACs (B) do not allow separate payment for an additional procedure(s) with a global surgery fee period if furnished during the postoperative period of a prior procedure and if billed without modifier “-58,” “-78,” or “-79.” These services should be denied. Codes with the global surgery indicator of “XXX” in the MFSDB can be paid separately without a modifier.

B. Claims From Physicians Who Furnish Less Than the Global Package (Split Global Care)

For surgeries performed January 1, 1992, and later, that are billed with either modifier “-54” or “-55,” *A/B MACs (B)* pay the appropriate percentage of the fee schedule payment. Fields 17-19 of the MFSDB list the appropriate percentages for pre-, intra-, and postoperative care of the total RVUs for major surgical procedures and for minor surgeries with a postoperative period of 10 days. The intra-operative percentage includes postoperative hospital visits.

Procedures with a “000” entry in Field 16 have an entry of “0.0000” in Fields 17-19. Split global care does not apply to these procedures.

A/B MACs (B) multiply the fee schedule amount (Field 34 or Field 35 of the MFSDB) by this percentage and round to the nearest cent. Assume that a physician who bills with a “-54” modifier has provided both preoperative, intra-operative and postoperative **hospital** services. Pay this physician the combined preoperative and intra-operative portions of the fee schedule payment amount.

Where more than one physician bills for the postoperative care, *A/B MACs (B)* apportion the postoperative percentage according to the number of days each physician was responsible for the patient’s care by dividing the postoperative allowed amount by the number of post-op days and that amount is multiplied by the number of days each physician saw the patient.

EXAMPLE

Dr. Jones bills for procedure “42145-54” performed on March 1 and states that he cared for the patient through April 29. Dr. Smith bills for procedure “42145-55” and states that she assumed care of the patient on April 30. The percentage of the total fee amount for the postoperative care for this procedure is determined to be 17 percent and the length of the global period is 90 days. Since Dr. Jones provided postoperative care for the first 60 days, he will receive $66 \frac{2}{3}$ percent of the total fee of 17 percent since $60/90 = .6666$. Dr. Smith’s 30 days of service entitle her to $30/90$ or $.3333$ of the fee.

$$6666 \times .17 = .11333 \text{ or } 11.3\%; \text{ and}$$

$$3338 \times .17 = .057 \text{ or } 5.7\%.$$

Thus, Dr. Jones will be paid at a rate of 11.3 percent (66.7 percent of 17 percent). Dr. Smith will be paid at a rate of 5.7 percent (33.3 percent of 17 percent).

C. Payment for Return Trips to the Operating Room for Treatment of Complications

When a CPT code billed with modifier “-78” describes the services involving a return trip to the operating room to deal with complications, *A/B MACs (B)* pay the value of the intra-operative services of the code that describes the treatment of the complications. Refer to Field 18 of the MFSDB to determine the percentage of the global package for the intra-operative services. The fee schedule amount (Field 34 or 35 of the MFSDB) is multiplied by this percentage and rounded to the nearest cent.

When a procedure with a “000” global period is billed with a modifier “-78,” representing a return trip to the operating room to deal with complications, *A/B MACs (B)* pay the full value for the procedure, since these codes have no pre-, post-, or intra-operative values.

When an unlisted procedure is billed because no code exists to describe the treatment for complications, *A/B MACs (B)* base payment on a maximum of 50 percent of the value of the intra-operative services originally performed. If multiple surgeries were originally performed, *A/B MACs (B)* base payment on no more than 50 percent of the value of the intra-operative services of the surgery for which the complications occurred. They multiply the fee schedule amount for the original surgery (Field 34 or 35) by the intra-operative percentage for the procedure (Field 18), and then multiply that figure by 50 percent to obtain the maximum payment amount.

$$[.50 \times (\text{fee schedule amount} \times \text{intra-operative percentage})]. \text{ Round to the nearest cent.}$$

If additional procedures are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery, *A/B MACs (B)* pay the additional procedures as multiple surgeries. Only surgeries that require a return to the operating room are paid under the complications rules.

If the patient is returned to the operating room after the initial operative session, but on the same day as the original surgery for one or more additional procedures as a result of complications from the original surgery,

the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not also apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for bilateral procedures that are required as a result of complications from the original surgery, the complication rules would apply. The bilateral rules would not apply.

D. MSN and Remittance Messages

When *A/B MACs (B)* deny separate payment for a visit because it is included in the global package, include one of the following statements on the MSN to the beneficiary and the remittance notice sent to the physician. Remittance messages and codes in detail can be found at:

<http://www.cms.hhs.gov/medlearn/appmsn.pdf>.

1. Messages for Fragmented Billing by a Single Physician

When a single physician bills separately for services included in the global surgical package, *A/B MACs (B)* include one of the following statements on the MSN and remittance advice.

MSN:

23.1 - “The cost of care before and after the surgery or procedure is included in the approved amount for that service. You should not be billed for this item or service. You do not have to pay this amount.” (add on message 16.34)

Remittance Record

“Claim/service denied/reduced because this procedure/service is not paid separately.” (Reason Code B15. Group code CO 97)

2. Messages for Global Packages Split Between Two or More Physicians

When a physician furnishes only the pre- and intra-operative services, but bills for the entire package, the following statements on the MSN and remittance advice.

23.5 - “Payment has been reduced because a different doctor took care of you before and/or after the surgery. You should not be billed for this item or service. You do not have to pay this amount.” (add on message 16.34)

Remittance Record

“Charges denied/reduced because procedure/service was partially or fully furnished by another physician.” (Reason Code B20, Group Code CO B20)

3. Message for Procedure Codes With “ZZZ” Global Period Billed as Stand-Alone Procedures

When a physician bills for a surgery with a “ZZZ” global period without billing for another service, include one of the following statements on the MSN and remittance notice.

A/B MACs (B) include the following message on the MSN for claims:

9.2 - “This item or service was denied because information required to make payment was missing.” (CO 16)

9.3 - "Please ask your provider to submit a new, complete claim to us."

(NOTE: Add on to other messages as appropriate).

16. When using 16, *A/B MACs (B)* should also use a claim remark code such as a return/reject code (MA 29MA 43, etc.) to show why claim rejected as incomplete.

4. Message for Payment Amount When Modifier "-22" Is Submitted Without Documentation

When a physician submits a claim with modifier "-22" but does not provide additional documentation, use the following or a similar remittance advice message:

9.7 - "We have asked your provider to resubmit the claim with the missing or correct information." (NOTE: Add on to other messages as appropriate.) MA 130

200 - Allergy Testing and Immunotherapy

(Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01-2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10)

A. Allergy Testing

The MPFSDB fee amounts for allergy testing services billed under codes 95004-95078 are established for single tests. Therefore, the number of tests must be shown on the claim.

EXAMPLE: If a physician performs 25 percutaneous tests (scratch, puncture, or prick) with allergenic extract, the physician must bill code 95004 and specify 25 units. To compute payment, the Medicare *A/B MAC (B)* multiplies the payment for one test (i.e., the payment listed in the fee schedule) by the quantity listed in the units field.

B. Allergy Immunotherapy

For services rendered on or after January 1, 1995, all antigen/allergy immunotherapy services are paid for under the Medicare physician fee schedule. Prior to that date, only the antigen injection services, i.e., only codes 95115 and 95117, were paid for under the fee schedule. Codes representing antigens and their preparation and single codes representing both the antigens and their injection were paid for under the Medicare reasonable charge system. A legislative change brought all of these services under the fee schedule at the beginning of 1995 and the following policies are effective as of January 1, 1995:

1. CPT codes 95120 through 95134 are not valid for Medicare. Codes 95120 through 95134 represent complete services, i.e., services that include both the injection service as well as the antigen and its preparation.
2. Separate coding for injection only codes (i.e., codes 95115 and 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170) must be used.

If both services are provided both codes are billed.

This includes allergists who provide both services through the use of treatment boards.

3. If a physician bills both an injection code plus either codes 95165 or 95144, *A/B MACs (B)* pay the appropriate injection code (i.e., code 95115 or code 95117) plus the code 95165 rate. When a provider bills for codes 95115 or 95117 plus code 95144, *A/B MACs (B)* change 95144 to 95165 and pay accordingly. Code 95144 (single dose vials of antigen) should be billed only if the physician providing the antigen is providing it to be injected by some other entity. Single dose vials, which

should be used only as a means of insuring proper dosage amounts for injections, are more costly than multiple dose vials (i.e., code 95165) and therefore their payment rate is higher. Allergists who prepare antigens are assumed to be able to administer proper doses from the less costly multiple dose vials. Thus, regardless of whether they use or bill for single or multiple dose vials at the same time that they are billing for an injection service, they are paid at the multiple dose vial rate.

4. The fee schedule amounts for the antigen codes (95144 through 95170) are for a single dose. When billing those codes, physicians are to specify the number of doses provided. When making payment, *A/B MACs (B)* multiply the fee schedule amount by the number of doses specified in the units field.
5. If a patient's doses are adjusted, e.g., because of patient reaction, and the antigen provided is actually more or fewer doses than originally anticipated, the physician is to make no change in the number of doses for which he or she bills. The number of doses anticipated at the time of the antigen preparation is the number of doses to be billed. This is consistent with the notes on page 30 of the Spring 1994 issue of the American Medical Association's CPT Assistant. Those notes indicate that the antigen codes mean that the physician is to identify the number of doses "prospectively planned to be provided." The physician is to "identify the number of doses scheduled when the vial is provided." This means that in cases where the patient actually gets more doses than originally anticipated (because dose amounts were decreased during treatment) and in cases where the patient gets fewer doses (because dose amounts were increased), no change is to be made in the billing. In the first case, *A/B MACs (B)* are not to pay more because the number of doses provided in the original vial(s) increased. In the second case, *A/B MACs (B)* are not to seek recoupment (if *A/B MACs (B)* have already made payment) because the number of doses is less than originally planned. This is the case for both venom and nonvenom antigen codes.
6. **Venom Doses and Catch-Up Billing** - Venom doses are prepared in separate vials and not mixed together - except in the case of the three vespid mix (white and yellow hornets and yellow jackets). A dose of code 95146 (the two-venom code) means getting some of two venoms. Similarly, a dose of code 95147 means getting some of three venoms; a dose of code 95148 means getting some of four venoms; and a dose of 95149 means getting some of five venoms. Some amount of each of the venoms must be provided. Questions arise when the administration of these venoms does not remain synchronized because of dosage adjustments due to patient reaction. For example, a physician prepares ten doses of code 95148 (the four venom code) in two vials - one containing 10 doses of three vespid mix and another containing 10 doses of wasp venom. Because of dose adjustment, the three vespid mix doses last longer, i.e., they last for 15 doses. Consequently, questions arise regarding the amount of "replacement" wasp venom antigen that should be prepared and how it should be billed. Medicare pricing amounts have savings built into the use of the higher venom codes. Therefore, if a patient is in two venom, three venom, four venom or five venom therapy, the *A/B MAC (B)* objective is to pay at the highest venom level possible. This means that, to the greatest extent possible, code 95146 is to be billed for a patient in two venom therapy, code 95147 is to be billed for a patient in three venom therapy, code 95148 is to be billed for a patient in four venom therapy, and code 95149 is to be billed for a patient in five venom therapy. Thus, physicians are to be instructed that the venom antigen preparation, after dose adjustment, must be done in a manner that, as soon as possible, synchronizes the preparation back to the highest venom code possible. In the above example, the physician should prepare and bill for only 5 doses of "replacement" wasp venom - billing five doses of code 95145 (the one venom code). This will permit the physician to get back to preparing the four venoms at one time and therefore billing the doses of the "cheaper" four venom code. Use of a code below the venom treatment number for the particular patient should occur only for the purpose of "catching up."
7. **Code 95165 Doses.** - Code 95165 represents preparation of vials of non-venom antigens. As in the case of venoms, some non-venom antigens cannot be mixed together, i.e., they must be prepared in

separate vials. An example of this is mold and pollen. Therefore, some patients will be injected at one time from one vial – containing in one mixture all of the appropriate antigens – while other patients will be injected at one time from more than one vial. In establishing the practice expense component for mixing a multidose vial of antigens, we observed that the most common practice was to prepare a 10 cc vial; we also observed that the most common use was to remove aliquots with a volume of 1 cc. Our PE computations were based on those facts. Therefore, a physician's removing 10 1cc aliquot doses captures the entire PE component for the service.

This does not mean that the physician must remove 1 cc aliquot doses from a multidose vial. It means that the practice expenses payable for the preparation of a 10cc vial remain the same irrespective of the size or number of aliquots removed from the vial. Therefore, a physician may not bill this vial preparation code for more than 10 doses per vial; paying more than 10 doses per multidose vial would significantly overpay the practice expense component attributable to this service. (NOTE: this code does not include the injection of antigen(s); injection of antigen(s) is separately billable.)

When a multidose vial contains less than 10cc, physicians should bill Medicare for the number of 1 cc aliquots that may be removed from the vial. That is, a physician may bill Medicare up to a maximum of 10 doses per multidose vial, but should bill Medicare for fewer than 10 doses per vial when there is less than 10cc in the vial.

If it is medically necessary, physicians may bill Medicare for preparation of more than one multidose vial.

EXAMPLES:

- (1) If a 10cc multidose vial is filled to 6cc with antigen, the physician may bill Medicare for 6 doses since six 1cc aliquots may be removed from the vial.
- (2) If a 5cc multidose vial is filled completely, the physician may bill Medicare for 5 doses for this vial.
- (3) If a physician removes ½ cc aliquots from a 10cc multidose vial for a total of 20 doses from one vial, he/she may only bill Medicare for 10 doses. Billing for more than 10 doses would mean that Medicare is overpaying for the practice expense of making the vial.
- (4) If a physician prepares two 10cc multidose vials, he/she may bill Medicare for 20 doses. However, he/she may remove aliquots of any amount from those vials. For example, the physician may remove ½ aliquots from one vial, and 1cc aliquots from the other vial, but may bill no more than a total of 20 doses.
- (5) If a physician prepares a 20cc multidose vial, he/she may bill Medicare for 20 doses, since the practice expense is calculated based on the physician's removing 1cc aliquots from a vial. If a physician removes 2cc aliquots from this vial, thus getting only 10 doses, he/she may nonetheless bill Medicare for 20 doses because the PE for 20 doses reflects the actual practice expense of preparing the vial.
- (6) If a physician prepares a 5cc multidose vial, he may bill Medicare for 5 doses, based on the way that the practice expense component is calculated. However, if the physician removes ten ½ cc aliquots from the vial, he/she may still bill only 5 doses because the practice expense of preparing the vial is the same, without regard to the number of additional doses that are removed from the vial.

C. Allergy Shots and Visit Services on the Same Day

At the outset of the physician fee schedule, the question was posed as to whether visits should be billed on the same day as an allergy injection (CPT codes 95115-95117), since these codes have status indicators of A rather than T. Visits should not be billed with allergy injection services 95115 or 95117 unless the visit represents another separately identifiable service. This language parallels CPT editorial language that accompanies the allergen immunotherapy codes, which include codes 9515 and 95117. Prior to January 1, 1995, you appeared to be enforcing this policy through three (3) different means:

- Advising physician to use modifier 25 with the visit service;
- Denying payment for the visit unless documentation has been provided; and
- Paying for both the visit and the allergy shot if both are billed for.

For services rendered on or after January 1, 1995, you are to enforce the requirement that visits not be billed and paid for on the same day as an allergy injection through the following means. Effective for services rendered on or after that date, the global surgery policies will apply to all codes in the allergen immunotherapy series, including the allergy shot codes 95115 and 95117. To accomplish this, CMS changed the global surgery indicator for allergen immunotherapy codes from XXX, which meant that the global surgery concept did not apply to those codes, to 000, which means that the global surgery concept applies, but that there are no days in the postoperative global period.

Now that the global surgery policies apply to these services, you are to rely on the use of modifier 25 as the only means through which you can make payment for visit services provided on the same day as allergen immunotherapy services. In order for a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series (i.e., any service in the series from 95115 through 95199), the physician is to bill a modifier 25 with the visit code, indicating that the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

D. Reasonable Supply of Antigens

See CMS Manual System, Internet Only Manual, Medicare Benefits Policy Manual, CMS Pub. 100-02 Chapter 15, section 50.4.4, regarding the coverage of antigens, including what constitutes a reasonable supply of antigens.